AFRICAN AMERICAN PATIENTS' LEVEL OF ACCULTURATION, PERCEIVED
CULTURAL SENSITIVITY, AND SATISFACTION WITH HEALTH CARE

By

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For my wife, Lora Ann Walter, whose friendship, support, assistance,

and unconditional love made this achievement possible.

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Abstract of Dissertation Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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This study examined African American veteran patients' level of acculturation, level of perceived cultural sensitivity in health care received, and level of satisfaction with health care received. An assessment battery, consisting of the following instruments, was administered by mail to 106 male African American veterans who received outpatient primary health care services at the Syracuse VA Medical Center: (1) The Patient Satisfaction Questionnaire Short-Form (PSQ-18); (2) The Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA); (3) The African American Acculturation Scale–Revised (AAAS–R); (4) The Marlowe-Crowne Social Desirability Scale–Short Form [M-C (20)]; and (5) A Demographic Questionnaire.

Results showed that patients' perceptions of their health care providers' level of cultural sensitivity was strongly and positively associated with patients' reported satisfaction with health care received. Patients' level of perceived cultural sensitivity

with health care received and whether patients were required to pay for their health care were significant predictors of their satisfaction with health care received such that higher satisfaction was associated with greater perceived cultural sensitivity in health care received and not being required to pay for health care received. Higher satisfaction was also associated with patients being older and of lower income; and perceived cultural sensitivity in health care received was associated with patients being older and less educated. Patients' level of acculturation was not significantly associated with either patients' perceptions of the level of cultural sensitivity in health care received or patients' reports of satisfaction with health care received. Finally, results of a MANCOVA showed no significant differences in patients' satisfaction or perceived cultural sensitivity in health care received as a function of their health care providers' gender. However, patients with ethnic minority, but not African American, health care providers perceived their providers to be less culturally sensitive than did patients with Caucasian health care providers. The implications of this research for the training of physicians in the provision of culturally sensitive health care, the role that psychologists can play in health care settings, the limitations of this study, and suggestions for future research are discussed.

CHAPTER 1
INTRODUCTION

Statement of the Problem

With the onset of the 21st century, physicians and other health care providers in

the United States are faced with the tremendous challenge of providing health care

services to an increasingly culturally diverse population. Recent estimates by the United

States Department of Commerce, Bureau of Census (2000) projected 9% population

growth in the United States between 1990 and 2000. Although Caucasian Americans

still account for the largest population group by race in the United States, their

population growth during this last decade was a mere 4%. The United States Census

Bureau's statistics show that greater projected population increases may be found among

America's ethnic minority groups. Specifically, during the decade from 1990 to 2000,

the United States Native American population grew by a projected 15%, the United

States Hispanic population grew by a projected 30%, and the United States Asian

population grew by a projected 33%. Moreover, given that the population of African

American citizens grew an estimated 13% over the last decade such that they comprise

nearly 13% of the nation's population, it is probably not surprising that Caucasian

Americans are predicted to be in the minority, demographically speaking, by the year

2056 (May, 1992).

With America increasingly assuming a multi-ethnic and multi-racial identity,

statistics such as these strongly support the need to provide culturally sensitive health

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care to meet the needs of an increasingly culturally diverse population. Unfortunately, current evidence suggests that ethnic minority groups such as African Americans do not enjoy the same level of health status as their Caucasian American peers, a finding that may be partly attributable to cultural differences.

For instance, African Americans and other racially/ethnically non-majority persons historically have been underserved by health care workers and institutions in the United States (Brookins, 1993). Current differences between African American and Caucasian American patients in both the availability of health care and the outcomes associated with health care delivery remain quite notable. Evidence shows that African American patients have the highest mortality rate for cancer of any United States population group; and that they have significantly higher mortality rates for hypertension, heart disease, cirrhosis, and diabetes than Caucasian Americans (Commonwealth Fund, 1999; Loue, 1999). Moreover, the average life expectancy of African Americans is approximately 6 years less than the average for Caucasian Americans (Anderson, 1991; Loue, 1999).

Given the above disparities in health-related outcomes between Caucasian Americans and African Americans, such findings beg the question, "What accounts for these disparities in health status?" The answer to this may lie in research showing that the failure to seek preventive health care or to adhere to prescribed medical treatment plans (e.g., to adhere to medical regimens, attend follow-up visits, etc.) is frequently associated with negative health care outcomes in patients (Brookins, 1993; Harris, Luft, Rudy, & Tierney, 1995; Levy, 1985; Loue, 1999). That is, African Americans and other ethnic minority members may be more prone than Caucasian Americans to underuse

health care (Brookins, 1993). Such a tendency to underuse health care may thus predispose African Americans and similar ethnic minorities to experience higher morbidity and mortality rates.

A common attribution for African Americans' underuse of health care is their lack of access to available medical health resources. That is, African American and other ethnic minorities may not have adequate health resources in proximity to where they live. Likewise, given that ethnic minorities are over-represented in low socioeconomic status (Levy, 1985), and that ethnic minority persons such as African Americans are more likely to lack health insurance relative to Caucasian Americans (Lieberman, Stoller, & Burg, 1997), ethnic minority group members such as African Americans may not be able to pursue medical care when it is available to them. Although it is undeniable that access to appropriate health services contributes to the disparity in use of healthcare services between African Americans and Caucasian Americans, research shows that these differences still exist even when financial incentives (e.g., health insurance) have been adjusted for (Loue, 1999).

Another reason for African Americans' underuse of health care services may lie in the disparity between African American patients' health-related beliefs, values, and practices; and those espoused by American health care professionals. That is, even under circumstances when appropriate health care is available and accessible to ethnic minority persons, such persons may perceive the health care that they receive as unacceptable and incongruent with their cultural beliefs and practices. This may be the case for African Americans, who have historically had their cultural beliefs, practices, and traditions ignored by clinicians and researchers alike. It has been suggested that many African

Americans may endorse cultural practices, values, and beliefs that are different from those espoused by other ethnic groups including Caucasian Americans (Anderson, 1991; Landrine & Klonoff, 1996). Moreover, there is evidence of considerable cultural heterogeneity among African Americans in terms of their beliefs and practices regarding religion, health care, diet, interracial attitudes, and family values, just to name a few (Landrine & Klonoff, 1995). Whereas some African Americans may be more "acculturated" in terms of their inclination to engage in or endorse the values, beliefs, and practices espoused by the White-European majority in America, other African Americans may prefer to engage in more "traditional" practices that are rooted in their African heritage.

It is this cultural heterogeneity and differences in level of acculturation among African Americans that may, in part, account for many African Americans' underutilization of health care resources. African Americans, particularly those who are less acculturated to the White-European values and practices espoused by nearly all American health care institutions, may be discouraged from pursuing health care and from complying with their health care providers' therapeutic recommendations when those recommendations are inconsistent with their cultural practices (Mokuau & Fong, 1994). Indeed, it has been widely suggested that ethnic minorities including African Americans may avoid seeking preventive or needed medical assistance or may avoid complying with the recommendations of their health care providers because they perceive their providers to be culturally insensitive (Brookins, 1993; Groce & Zola, 1993; Landrine & Klonoff, 1996; Levy, 1985; Mokuau & Fong, 1994; Spector, 1996; Weddington, Gabel, Peet, & Stewart, 1992). Such insensitivity may in part be attributed

to the lack of cultural diversity among providers. Specifically, less than 7% of American physicians and medical school faculties are from an ethnic minority group (including African Americans, Hispanic Americans, and Native Americans collectively) and minority group members' entering medical school are declining at a rate higher than Caucasian entrants into medical school (Commonwealth Fund, 1999; Srinivisan, 1997). The notion that African Americans and other ethnic minorities may perceive their care as culturally insensitive is further supported by research showing that African American patients tend to be less satisfied relative to Caucasian patients with the health care that they receive (Landrine & Klonoff, 1994; Litt & Cuskey, 1984).

Patient satisfaction is an important construct because it has been empirically determined that patients who are dissatisfied with the health care that they receive tend to have poorer continuity of health care and are more likely to pursue medical malpractice (Falvo & Smith, 1983). Moreover, given the finding that patient satisfaction is the most important determinant of compliance to medical regimens (Litt & Cuskey, 1984), it should not be surprising that dissatisfaction with health care received is associated with negative health outcomes. Collectively, this evidence paints a picture of African Americans and other ethnic minorities being at greater risk to experience negative health outcomes when they perceive their care to be culturally insensitive and are less satisfied with the health care that they receive.

Although the above issues have important implications for most, if not all, ethnic minority groups, it is essential that research focus on specific populations in order to most appropriately understand each cultural group (Sue, Chun, & Gee, 1995).

Accordingly, research is needed to examine the following:

- The degree to which physicians and other health care providers are perceived by African Americans as being culturally sensitive.

- How such perceived cultural sensitivity may relate to important outcome variables such as patient satisfaction with health care received.

- The variables that may influence this potential relationship between perceived cultural sensitivity and patient satisfaction.

The exploratory project being proposed has as its goals to assess and examine the associations among African American veteran outpatients':

- Perceived level of cultural sensitivity experienced in the health care that they receive.

- Level of acculturation.

- Level of satisfaction with health care that they receive.

Need for the Study

One catalyst for this investigation is the paucity of research on African Americans' perceptions of the quality of health care that they receive. Another catalyst is how these perceptions relate to their satisfaction with their health care. Despite the widespread calls and suggestions for increased cultural sensitivity by health care professionals to enhance health outcomes in ethnic minorities, little empirical research has focused on:

- The degree to which African Americans actually perceive their health care to be culturally sensitive.

- The factors that may influence such perceptions.

- How such perceptions relate to outcomes such as the satisfaction that they report.

This investigation focuses specifically on African American veteran outpatients who have received outpatient health care services at a Veterans Affairs (VA) Medical Center. Although demographic data shows that only 8.6% of American Veterans were of African American ethnicity in 1990, more recent statistics project that nearly 20% of current active-duty armed forces personnel are African Americans (VA Office of Program and Data Analyses, 2000). Such data suggest that a much higher proportion of African American veterans will become consumers of health care, and that health care agencies need to be especially prepared to provide culturally sensitive and quality health care to African American patients.

Although no research has compared the health status of African American veterans and non-veterans, it is assumed that African American veterans experience the same disparity in health status as African American non-veterans. Indeed, evidence shows that African American veterans may even be at greater risk of certain psychiatric disturbances (e.g., Post Traumatic Stress Disorder) than Caucasian American veterans or non-veteran populations (Rosenheck, Fontana, & Cottrol, 1995). Just as for African American non-veterans, the limited available research on African American veterans shows that they too may be more likely to underuse VA health care services (Lefkowitz, Snow, & Cadigan, 1990; Rosenheck et al., 1995) and be dissatisfied with the health care services that they receive (Young, Meterko, & Desai, 2000) relative to Caucasian American veterans.

The present exploratory investigation therefore assesses and examines the associations among African American veteran outpatients' perceived level of cultural sensitivity in the health care that they receive, their perceived level of satisfaction with

the health care they receive, and their reported level of acculturation. Benefits that may

be gained by this investigation include the following:

- Empirical support for training health care providers in providing culturally sensitive health care to African American patient consumers.

- Identification of ways that psychologists can enhance the patient care of African Americans by way of targeting and altering health care providers' behaviors and practices so as to facilitate cultural sensitivity in care.

- A better understanding of whether and how African Americans' level of acculturation may be associated with their health-related beliefs, attitudes, behaviors, and perceptions.

- Identification of ways of enhancing African Americans' satisfaction with their health care and, consequently, the health outcomes that they experience.

- An impetus for further research on providing culturally sensitive health care for African American patients, and other non-majority patients, in an effort to promote health and prevent illness in these patients.

<u>Purpose and Hypotheses of This Investigation</u>

The purpose of this exploratory study is to assess and examine the associations

among African American veteran patients':

- Level of perceived cultural sensitivity in the health care that they receive.

- Level of perceived satisfaction with the health care they receive.

- Reported level of acculturation.

Specifically, I tested the following hypotheses:

<u>Hypothesis 1</u>. There is a significant positive association between African

American veteran outpatients' level of satisfaction with their health care and their level

of acculturation (i.e., more acculturated versus more traditional). Specifically, it is

anticipated that the greater the degree of acculturation in African American patients, the

greater their satisfaction with their health care.

Hypothesis 2. There is a significant positive association between African American veteran outpatients' level of acculturation and the degree to which they perceive their health care providers and health care environments to be culturally sensitive. It is anticipated that African American patients who are more acculturated are more likely than less acculturated patients to perceive their health care as culturally sensitive.

Hypothesis 3. The degree to which African American veteran outpatients perceive their health care to be culturally sensitive has a significant positive association with their level of satisfaction with their health care.

Hypothesis 4. Among African American veteran outpatients, the relationship between patients' level of perceived cultural sensitivity in their health care and their reported level of satisfaction with their health care is significantly influenced by their level of acculturation.

In addition to the above hypotheses, I address two research questions:

Research Question 1. Among African American veteran outpatients, are there significant differences in patients' level of perceived cultural sensitivity in health care received, level of satisfaction with health care received, and level of acculturation in association with patients' age or education level?

Research Question 2. Are there significant differences in African American veteran outpatients' level of perceived cultural sensitivity in health care received and satisfaction with health care received in association with the gender or ethnicity of their health care providers?

CHAPTER 2
REVIEW OF THE LITERATURE

This literature review focuses on the literature that is relevant to the variables

investigated in this study. These variables include patient satisfaction with health care

received, perceived cultural sensitivity in health care received, and level of acculturation.

Relevant research regarding how these variables may be related is discussed. Literature

regarding the relationship of patients' age and level of education to their satisfaction

with health care received, perceived cultural sensitivity in health care received, and level

of acculturation are reviewed. Research regarding how health care providers' age and

ethnicity may be related to patients' reported satisfaction with their health care and level

of perceived cultural sensitivity in health care received are reviewed. Also, empirical

evidence that is relevant to African American veteran patients' use of health care

resources, compliance with prescribed health care regimens, and satisfaction with health

care are briefly discussed.

<div align="center">Patient Satisfaction</div>

What Is Patient Satisfaction and How Is It Studied?

"Patient satisfaction is defined as a health care recipient's reaction to salient

aspects of the context, process, and result of their service experience" (Pascoe, 1983, p.

189). It is believed that patients are prone to perceive the health care services that they

receive in an evaluative manner, much as consumers evaluate services they receive in

other aspects of the public sector (e.g., service while dining in a restaurant, etc.). It is argued that this evaluative process is rooted largely in patients' "expectations (e.g., beliefs), values (whether aspects of the health care encounter are important), and sense of entitlement (e.g., the belief that he or she has the right to experience a certain outcome)" (DiPalo, 1997, p. 424). Testimony to the importance of patient satisfaction is the tremendous effort and widespread use of surveys by health care agencies across the nation to evaluate the perceptions that health care consumers have about their health care experiences.

Unfortunately, the tremendous amount of literature on patient satisfaction has been plagued with problems and limitations. These problems include the lack of a theoretical framework or consensus of definition for the investigations of patient satisfaction, the use of numerous methods for measuring patients' satisfaction, and the diversity in populations and health care contexts in which patient satisfaction is evaluated.

One major limitation researchers have had to deal with in attempting to measure patient satisfaction has been the lack of theoretical development regarding the construct of patient satisfaction. Williams (1994) reviewed and discussed the lack of consensus regarding a theoretical basis for the construct of patient satisfaction and regarding how best to operationally define this construct. This state of affairs has impeded an accurate understanding of patient satisfaction. Not surprisingly, the plethora of patient satisfaction research affects investigators' choice of which dimensions of patients' health care experiences to evaluate (e.g., should patient satisfaction entail satisfaction with the physician's interpersonal manner, physician's technical ability, the length of wait for

health care service, satisfaction with health care outcome(s), cost of services, etc.). Recent research by Marshall, Hays, Sherbourne, & Wells (1993) has suggested that patient satisfaction may be a multifaceted construct which can be represented hierarchically with an overarching domain of general satisfaction.

Other issues that plague patient satisfaction literature are the diversity of methods and the patient populations targeted. There is no consensus regarding how to best measure this construct. Moreover, the diversity of patient sociodemographic variables included in the literature (e.g., some studies have only examined patient satisfaction in women, the elderly, etc.) and the types of health care patients examined (e.g, inpatients versus outpatients, primary versus tertiary care patients, chronically ill versus acutely ill patients, etc.) have posed another challenge to obtaining a clearer understanding of the construct of patient satisfaction. Such different patient populations likely have different experiences with the health care system and are likely to evaluate different facets of their care. Accordingly, caution is to be exercised when attempting to generalize satisfaction research on patients with particular clinical disorders or in particular domains (e.g., inpatient versus outpatient, etc.).

Despite these problems and the diversity with which various investigators have attempted to study patient satisfaction, the study of patient satisfaction remains one of the most studied variables in the health care literature (van Campen, Sixma, Friele, Kerssens, & Peters, 1995). Perhaps the largest proportion of investigations into this area have used self-report instruments in order to acquire patients' perceptions of their satisfaction with their health care. Several reviews (Medical Outcomes Trust, 1998; Ross, Steward, & Sinacore, 1995; van Campen et al., 1995) identified the most common

patient satisfaction instruments cited in the literature and compared their strengths and
weaknesses. Van Campen et al. (1995) reported in a meta-analysis of 221 patient
satisfaction studies that the most frequently yielded dimensions of evaluating satisfaction
with health care included humaneness, informativeness, overall quality, competence,
overall satisfaction, bureaucracy, access, cost, facilities, outcome continuity, and
attention to psychosocial problems. Fortunately, a measure exists that greatly accounts
for many of these dimensions. The taxonomy of the Patient Satisfaction Questionnaire
(PSQ), developed by Ware, Snyder, Wright, and Davies (1983), arguably best covers
these dimensions (van Campen et al., 1995, pp.125). The PSQ is one of the most widely
used measures of satisfaction with medical care (Marshall et al., 1993), and all of its
dimensions are in the top ten most investigated dimensions examined in patient
satisfaction research (Hall & Dornan, 1990).

Need for Studying Patient Satisfaction

The degree to which health care consumers are satisfied with their health care
is an issue that has been examined by social scientists for well over a half century and
has been cited over 3,000 times in the literature (van Campen et al., 1995). Moreover,
patient satisfaction can be found as an outcome measure in virtually every standardized
system of evaluating health care presently being used. Specifically, it is an outcome
measure endorsed and used by such agencies as the National Committee for Quality
Assurance (NCQA), the Foundation for Accountability (FACCT), and the Joint
Commission for the Accreditation of Healthcare Organizations, just to name a few
(DiPalo, 1997).

Studying patient satisfaction has been perceived as important because of the implications it may have for patients and health care agencies alike. Specifically, differences between satisfied and dissatisfied health care consumers may affect patients' health-seeking behaviors such as the health care agencies where they choose to pursue their care. Additionally, patient differences in satisfaction with health care may be predictive of the health outcomes such patients experience.

Satisfied Patients as Health Care Consumers

An obvious reason that patient satisfaction continues to be widely studied in the provision of health care is that it is important to the financial benefit of health care providers and organizations. With the coming of the consumer movement in health care over the last decade, patient satisfaction has increasingly become an important outcome variable and marker of health care performance. Indeed, today's health care providers and facilities compete with each other to provide the most effective form of health care to patients and to provide it in a manner that reinforces patients' willingness to seek their services in the future. Indeed, research by Ware and Davies (1983) showed that dissatisfied patients are more likely than satisfied patients to engage in "doctor shopping" and to voluntarily disenroll from their medical health plans. Moreover, it has been argued that dissatisfied patients may be prone to sharing their negative experiences (i.e., "bad-mouthing") with other consumers (Cohen, Delaney, & Boston, 1994). Such negative publicity undoubtedly jeopardizes the potential revenues that health care providers and organizations can earn. Hence, health care related research has been increasingly driven by greater accountability in the quality of care that patients receive (DiPalo, 1997).

Patient Satisfaction and Health Status/Outcomes

Patient satisfaction with their health care is an important research focus because it has been empirically linked to health care outcomes that patients experience. Just as patient satisfaction has been examined as a dependent variable in health research because of its financial implications for health care agencies, so too has patient satisfaction been regarded as a potentially important independent variable in terms of its association with patient behavior and health status. Specifically, an empirical review by Cleary and McNeil (1988) showed that most studies they reviewed showed a positive correlation between health status and patient satisfaction.

Likewise, research shows that patients who are more satisfied with the health care that they receive also report being in better health or experiencing better health outcomes (Hall & Dornan, 1990; Pascoe, 1983; Stewart, Meredith, Brown, & Galajda, 2000). For instance, Stewart (1995) reviewed research published between 1983 and 1993 regarding patient-physician communication and patient satisfaction that not only showed that these issues are positively correlated with one another, but they are also associated with positive health outcomes on indices including symptom resolution, role limitation, blood pressure, and pain (Stewart, 1995; Stewart et al., 2000). Similarly, empirical reviews have reported that greater patient satisfaction was positively associated with patients' perceptions of their overall health, physiological and psychosocial functioning, and physician ratings of patient health (Hall, Feldstein, Fretwell, Rowe, & Epstein, 1990; Hall, Milburn, & Epstein, 1993; Pascoe, 1983). Moreover, a study by Harris et al. (1995) seems to support this relationship between patient satisfaction and health outcomes among African American patients. These investigators found that dissatisfaction with

health care in African American patients with hypertension and chronic renal insufficiency was associated with a host of negative health experiences and outcomes including decreased medication adherence, higher blood pressure, and increased symptoms associated with anti-hypertensive drug therapy.

Although research generally shows that patient satisfaction is closely related with patients' health status and the quality of health outcomes that patients report, it is interesting to note that existing studies to date have not been able to conclusively determine the functional relationship between patient satisfaction and health outcomes/status (i.e., whether patient satisfaction moderates patient behavior such that they experience better health outcomes, or whether patients who experience better health outcomes simply report greater satisfaction). Nevertheless, satisfied patients are perceived as expending more energy and effort in their treatment and consequently experiencing more optimal health outcomes than their dissatisfied peers (Pascoe, 1983).

It has been well established in the literature that patient satisfaction is positively associated with more continuous health care, compliance and adherence to medical regimens, and better health (DiPalo, 1997; Greenfield & Attkisson, 1989; Hall & Dornan, 1990; Hall, Milburn, & Epstein, 1993; Harris et al., 1995; Pascoe, 1983). For instance, Ware, Davies-Avery, and Stewart (1978) reported that 26 of the 30 studies that they reviewed showed that satisfied health care consumers used health care services more frequently than dissatisfied consumers did. Such findings certainly lend support to the notion that people who are satisfied with the health care that they receive are less reluctant to pursue medical assistance than dissatisfied patients, thereby increasing satisfied patients' chances for optimal health consequences.

In addition, a review by Pascoe (1983) on the provision of primary health care showed that patients who are satisfied with the health care service they receive are more likely to comply and adhere to their health care provider's recommendations than dissatisfied patients are (Pascoe, 1983). That is, satisfied and dissatisfied patients may make different decisions in their health seeking behaviors and compliance to medical regimens, with dissatisfied consumers being less apt to follow through with beneficial health behaviors and to adhere to medical regimens as prescribed (Greenfield & Attkisson, 1989). Satisfied health care consumers, in contrast, are more likely to follow through with medical appointment-keeping and follow-up visits, to follow physician instructions, and to comply with and adhere to medication requirements (Litt & Cuskey, 1984; Pascoe, 1983).

In summary, the above findings generally show a positive association between patient satisfaction and health status. Likewise, patient satisfaction has been empirically linked to patients' health-seeking behaviors (e.g., health care use, complying with medical recommendations and regimens, etc.). The finding that satisfied health care consumers may be more prone to participate in their treatment, relative to dissatisfied consumers, may help reduce possible short-term or long-term complications associated with disease or course of treatment. Such findings paint a dismal picture for the dissatisfied health care consumer who may be at greater risk for negative health outcomes associated with his or her lack of compliance with medical recommendations.

Sociodemographic Characteristics Associated with Patient Satisfaction

Hundreds of studies have assessed the relationship of sociodemographic characteristics (such as age, sex, race or ethnicity, and social status) to patient

satisfaction with health care received. Fortunately, several reviews summarized such information. Hall and Dornan (1990) offered one of the most comprehensive reviews and evaluations of research on sociodemographic variables associated with patient satisfaction. Their review of the literature showed that background variables such as age, sex, and race or ethnicity often yield inconsistent or weak relationships with the satisfaction with health care received that patients report. Aside from their literature review, these investigators performed a meta-analysis of 110 studies to examine the relation between patients' sociodemographic characteristics and their satisfaction with medical care. Although the results from the meta-analysis showed that the relationships were typically small and accounted for very little of the variance associated with patient satisfaction, results did show that being older, being of higher social status, being Caucasian, and being married were associated with reports of greater satisfaction with health care received.

Although a number of literature reviews regarding the relationship between patients' sociodemographic characteristics and their satisfaction with health care (e.g., Aharony & Strasser, 1993; Cooper-Patrick et al., 1999; Pascoe, 1983) corroborate the meta-analytic findings reported by Hall and Dornan (1990), some contradictory findings have been reported. For example, Hall and Dornan reported that patient education level did not predict differences in patient satisfaction independent of other variables, but that it did interact with patient ethnicity to affect patient satisfaction. That is, statistical contrasts revealed that less educated White adults reported greater satisfaction with health care received than less educated Black or Hispanic adults. However, still others

reported that higher patient education level across ethnicity is positively associated with greater satisfaction with health care received (Litt & Cuskey, 1984).

In addition, despite the consensus of research showing that elderly patients may report greater satisfaction with their health care, some discrepant findings have been reported for elderly ethnic minorities. Hulka, Krupper, Daly, Cassell, and Schoen (1975) reported that African Americans above age 60 were most likely to be dissatisfied with costs and access issues associated with health care. Moreover, Aharony and Strasser (1993) reported that investigations of patient satisfaction have had an under representation of non-respondents who are younger than age 40, non-Caucasian, and of low socioeconomic status. Collectively, these findings show that further scrutiny of patient satisfaction associated with ethnic minority persons' age and education level is deserving. Hence, part of the purpose of the present investigation is to assess such variables in relation to the satisfaction reported by African American veteran outpatients.

Patient Satisfaction among African American Patients

Although Hall and Dornan's (1990) meta-analytic results did not exhibit a clear distinction between satisfaction with health care levels reported by Whites and Blacks or Hispanics, several pertinent trends were reported. These included a tendency for those of higher income to be more satisfied, a tendency for Whites of higher social status to be more satisfied than Blacks or Hispanics of higher social status, and a tendency for Whites of lower education status to be more satisfied than Blacks or Hispanics of lower education status.

Although the above findings may suggest, as Hall and Dornan contend, that race or ethnicity only plays a small role in the type of satisfaction patients report, a couple of

considerations are deserving. First, the meta-analysis performed by Hall and Dornan compared Whites to both Blacks and Hispanics, combined. The combination of these two ethnic groups (i.e., Blacks and Hispanics), lumped together as one for their analyses, greatly undermines the heterogeneity of satisfaction that these groups may experience in health care. Specifically, if Hispanics were more prone to be dissatisfied with certain dimensions of health care and very satisfied with others aspects, while Blacks were likely to be inversely more satisfied with dimensions that Hispanics reported dissatisfaction with, then combining such reported experiences may yield a level of satisfaction that inaccurately represents both groups. In addition, it is disconcerting that Hall and Dornan (1990) reported significantly more dissatisfaction with health care received among economically and educationally impoverished Blacks and Hispanics, relative to educationally and economically impoverished Caucasian Americans. Given evidence that Blacks and Hispanic Americans are over-represented among lower socioeconomic status levels suggests that members of these ethnic minority groups are proportionally more at risk than Caucasian Americans for being dissatisfied with their health care received and for experiencing negative health outcomes.

Indeed, an aggregate of evidence suggests that ethnic minority group members, and African Americans in particular, are at greater risk for being dissatisfied with the health care that they receive (Blendon, Aiken, Freeman, & Corey, 1989; Clark, Pokorny, & Brown, 1996; Cooper-Patrick et al., 1999; Harris et al., 1995; Litt & Cuskey, 1984; Morales, Cunningham, Brown, Liu, & Hays, 1999; Ware & Davies, 1983). For instance, Clark, Pokorny, and Brown (1996) conducted a study to assess Caucasian and African American patients' satisfaction with nursing care. Although results showed that all

patients were generally satisfied, African American patients were significantly less satisfied with the degree of discharge teaching provided to them. These authors appropriately pointed out that such dissatisfaction could have negative consequences as it may hinder African American patients' ability to adequately follow post-care health procedures and thereby put them at greater risk to experience negative health outcomes.

Similarly, a national telephone survey by Blendon et al. (1989) that was performed to assess Blacks' use of health care services revealed that Blacks experience both a significant deficit in access to and dissatisfaction with health care. Although the authors of this investigation concluded that access issues may contribute to the dissatisfaction African American patients report in their experience with the health care delivery system, they also suggested that the qualitative ways in which physicians treat these patients may also contribute. In fact, it has been pointed out that "differences in socioeconomic status and health insurance coverage between patients only partially explain the observed racial differences in health care" (Cooper-Patrick et al., 1999, p. 583). Blendon et al. (1989) found that Blacks as compared to Whites are much less satisfied with the qualitative ways that their physicians treat them and more strongly believe that the duration of their most recent hospitalization was too short.

A study of patient satisfaction by Ware and Davies (1983) is also worth noting. These authors assessed the patient satisfaction of 323 health care patients, 90% of whom were economically disadvantaged African American health care consumers. They reported that African Americans' satisfaction with the health care they received was closely associated with the interpersonal manner of their health care providers. In fact, the authors reported that African American patients who were dissatisfied with their

health care and the interpersonal manner of their regular health care providers were significantly less likely, relative to Caucasian patients, to pursue medical treatment through these health care providers for more serious symptoms (i.e., African Americans were twice as likely, relative to Caucasian patients, to go to the emergency room than see their regular health care provider).

Hazzard, Hutchinson, and Krawiecki (1990) evaluated the satisfaction of pediatric seizure patients and examined the association of their satisfaction with patient adherence to medication. Approximately 91% of their patient sample was comprised of African Americans. Results showed that both parent and child satisfaction with medical care received were positively correlated with the child's medication adherence. Their findings corroborate the report of Harris et al. (1995) that African American patients with hypertension and chronic renal insufficiency who were dissatisfied with their health care were at greater risk for being less compliant with their medical regimen and for experiencing negative health outcomes. Collectively, these findings suggest that dissatisfaction with health care among African American patients may impact their health care decision-making and treatment adherence and may increase their risk of experiencing negative health outcomes as well.

A recent investigation by Cooper-Patrick et al. (1999) sheds further light on the dissatisfaction African Americans are prone to experience in relation to health care agencies. These authors point out that African Americans are not only more likely to be dissatisfied with the health care that they receive, but that such dissatisfaction may stem from lack of participatory interactions with their health care providers. Results of their review of relevant research and of their own telephone survey showed that African

American health care consumers perceived that their health care providers involved them significantly less in their treatment decision-making (i.e., participatory style) relative to Caucasian patients. This finding was particularly true in instances in which African American patients' health care providers were different in race or ethnicity from themselves. This study provides strong evidence that lower patient satisfaction among African American patients may be a result of poor communication between such patients and their health care providers on account of the ethnic discordance in the patient-physician relationship.

The above findings provide evidence that African Americans are at risk to experience less satisfying health care relative to Caucasian health care consumers. When considering that dissatisfaction with health care received is associated with potentially negative health outcomes for consumers and lost revenues for health institutions, further attention to factors associated with health care dissatisfaction reported among African Americans is merited. A goal of the present investigation is to identify potential factors (i.e., perceived cultural sensitivity, level of acculturation, sociodemographic variables, and health care provider variables) associated with patient satisfaction among African Americans. Identifying such potential factors may contribute to a better understanding of African American patients' health care experiences and ways of enhancing their health status/outcomes.

Cultural Sensitivity in Providing Health Care

Although there is no universal definition of culture, Huff and Kline (1999) discuss several criteria for the definition of culture including having a common pattern of communication or language unique to the group; similar dietary preferences; common

patterns of dress; common and predictable social interaction patterns among members of the culture; and a common set of shared values and beliefs. Because all persons in all societies live within a fabric of culture, it is impossible to escape its influence (Steiner, 1992). Accordingly, people of different ethnic and cultural backgrounds are likely to have beliefs and values that are different from other groups. Such differences are apt to appear in the context of the provision of health care when patients and providers are from different cultural backgrounds. When cultural differences exist between health care providers and their patients, there is greater risk that these differences may not only limit the patient-physician therapeutic alliance (e.g., communication difficulties may arise), but may jeopardize the quality of care and health outcomes culturally different patients might experience (Levy, 1985). It has been widely suggested that health care providers and institutions who can more sensitively and competently address these cultural differences in the provision of health care may be able to better care for and enhance the health outcomes of their culturally different patients (Die Trill & Holland, 1993; Groce & Zola, 1993; Grossman, 1994; Levy, 1985; Lieberman et al., 1997; Patterson & Blum, 1993; Ridley, 1995; Spector, 1996, Stewart et al., 1999).

It is undeniable that health care facilities and training institutions in the United States still largely endorse Western value-laden health belief systems that are European-American oriented, with major emphasis on illness as a person-centered process, irrespective of reference to spiritual or familial experiences and values (Landrine & Klonoff, 1996; Pierce, 1997). However, such intrapersonal value systems may not be consistent with those practiced by many ethnic minorities such as African Americans. For many members of ethnic minority groups, including African Americans, treatment

modalities that incorporate prayer and folk remedies may be more preferred methods for treating illness than pharmacological or surgical procedures (Pierce, 1997; Spector, 1996). For instance, Groce and Zola (1993) reported that reliance on faith in God may take precedence over conventional medical recommendations among critically ill African American patients whose families are closely affiliated with the church. Moreover, both the etiology and phenomenological experience of illness may be perceived differently by patients and their caregivers. Whereas American medical practitioners, who are mostly Caucasian American, are likely to attribute the cause of an illness to biological factors, it has been suggested that ethnic minority group members including African Americans may be more apt to attribute the cause of illness to cultural or spiritual reasons (Groce & Zola, 1993; Grossman, 1994; Winbush, 1996).

What makes the issue of caring for African American patients in a manner that represents understanding and respect for their cultural beliefs and practices all the more important is recent statistics indicating that the number of African American health care providers may be on the decline. The number of African Americans being admitted to medical school is decreasing, a statistic that undoubtedly is associated with the removal of affirmative action legislation in certain states (Srinivisan, 1997). Moreover, statistics show that African Americans comprise only about 4% of all physicians in the United States (King & Brunetta, 1999). Such a low percentage is proportionally less than the percentage of African American citizens in the United States. What makes this discrepancy between the proportion of African American physicians and the African American population in the United States disconcerting is African American patients' preference for African American health care providers. Specifically, evidence indicates

that ethnic minority patients, including African Americans, are five times more likely than Caucasian patients to report that their regular physician is an ethnic minority group member (Gray & Stoddard, 1997). These statistics not only indicate that African Americans prefer to seek the assistance of health care providers who are similar to themselves in ethnicity, it also suggests that the availability of health care providers similar to themselves in ethnicity may be limited. Such statistics point to the possibility that African American patients may perceive that they have limited and inadequate health care resources available to them.

In response to African Americans' preference for ethnically-similar health care providers, there has been an urgent call in the health care profession for providers to be more "culturally sensitive" in their treatment of persons who are culturally different from themselves. Although efforts over the last decade have been made to increase the "cultural sensitivity" of health care providers to meet the demands of the increasing ethnic minority populations, recent evidence shows that less than 2% of United States Medical Schools require cultural-sensitivity training as part of the curriculum (Lum & Korenman, 1994). Such dismal statistics may be largely attributable to the lack of consensus and understanding with regard to what goes into such a curriculum.

Providing Culturally Sensitive Health Care

Cultural sensitivity in the provision of health care has been defined as "the clinician's willingness to identify and incorporate into their care their patients' culturally based attitudes, values, and beliefs about their health and health care, expectations of the clinician's role, and preferred communication style" (Stewart et al., 1999, pp. 321). Although this definition may appear to offer a comprehensive account for the construct

of cultural sensitivity, it is only one of numerous definitions that have been offered in the literature. In fact, a widely accepted operational definition of what entails providing culturally sensitive health care has not been forth coming.

Rather, many professionals in both psychology and the medical professions have suggested a number of recommendations for health care providers to follow when caring for ethnic minority group members (see Die Trill & Holland, 1993; Groce & Zola, 1993; Grossman, 1994; Levy, 1985; Lieberman et al., 1997; Patterson & Blum, 1993; Ridley, 1995; Spector, 1996, Stewart et al., 1999). For instance, it has been recommended that health care providers become aware of different cultural practices (e.g., patients' conception of time may be circular as opposed to linear) and communication patterns (e.g., degree of eye contact, etc.) when caring for persons who are ethnically different than themselves. Having health care providers identify their own prejudices is also encouraged. Considering that most, if not all, persons possess certain prejudices against certain persons, it is possible that even at an unconscious level health care providers may react negatively to patients who they may have prejudice against (e.g., Caucasian health care providers, who may have some degree of prejudice towards African Americans, may unconsciously make such patients wait longer, be not as thorough during the examination, etc.). Indeed, it has been reported that upwards of 14% of African American patients have reported being discriminated against in the health care that they have received, as opposed to only 1% among Caucasian patients (Stewart et al., 1999).

It has also been recommended that health care professionals increase their cultural sensitivity by communicating with patients at an educational level and language (if possible) that the patient is able to comprehend. Moreover, medical professionals

should familiarize themselves with psychosocial aspects of the patient's care so that they can devise a treatment plan that the patient is capable of fulfilling (Levy, 1985). It has been encouraged that health care providers invest time into trying to understand the patient's world views and practices, consult with peers and members of the community who are culturally different from themselves when necessary, and familiarize themselves with community resources that can serve as liaisons for under served ethnic minority patients (Groce & Zola, 1993; Levy, 1985; Patterson & Blum, 1993). Such efforts could provide health care providers with a more genuine understanding and respect for the patient's health-related views. Likewise, health care professionals must be careful not to stereotype ethnic minority patients given the heterogeneity of socialization ethnic minority group members may have. Lastly, it has been recommended that culturally sensitive health care include open communication (e.g., appropriately offering explanations, eliciting patient concerns, etc.), courtesy, and respect for the patient's health-related practices and beliefs (Stewart et al., 1999).

Despite the increasing attention being given to the issues associated with providing culturally sensitive health care in the literature over the last decade, little attention has been given to the patient's perspective of what connotes culturally sensitive health care. That is, despite the multitude of efforts to operationally define "culturally sensitive" health care and the numerous recommendations made by clinicians and researchers for its provision, there is a paucity of research devoted to understanding the health care issues that ethnic minority patients, and African Americans in particular, perceive as being culturally sensitive. Such lack of empirical exploration is evidence that there is currently an inadequate understanding of how and to what degree African

American health care consumers perceive their care as culturally sensitive. Given African Americans greater morbidity and mortality rates, and that they are more susceptible to experience negative health outcomes including dissatisfaction with the care that they receive, it is plausible that the lack of cultural understanding and congruence in the patient-physician relationship may account for African Americans being at greater risk to experience negative health outcomes.

An investigation in process by Tucker, Pedersen, Walter, Ivery, and Higley (2001) is thought to be one of the first empirical efforts aimed at identifying what ethnic minority patients regard as culturally sensitive health care. Specifically, these researchers are undertaking a "grass roots" campaign to investigate what factors and variables African American, Hispanic American, and Caucasian American primary care patients perceive as culturally sensitive in the health care that they receive. Toward this end, these researchers have conducted focus groups wherein African American, Hispanic American, and Caucasian American patients have separately identified those health care provider, staff, and health care environment variables that they regard as important in providing culturally sensitive health care. It is intended that their research will not only help shed light on the issues and variables associated with providing culturally sensitive health care and important health care indices (e.g., patient satisfaction), but will provide useful information for the training of health care professionals and staff in the provision of optimal health care for ethnic minority patients. In association with the research by Tucker et al. (2001), this investigation aims to gain a clearer understanding of the degree to which African American veteran outpatients perceive their health care received as culturally sensitive.

Relationships among Culturally Sensitive Health Care, Patient Satisfaction, and
  Health Outcomes

Investigators have suggested that African American patients' cultural beliefs
about health and illness and the lack of congruence between those of their health care
providers may adversely affect the health-related behaviors and outcomes such patients
experience (Pierce, 1997; Winbush, 1996). For instance, when treatment
recommendations conflict with African American patients' cultural or religious beliefs,
such patients are more inclined to feel alienated or that their providers are not
considering their best interests (McCubbin, Thompson, Thompson, McCubbin, &
Kaston, 1993). Accordingly, such patients may be less inclined to follow through with
therapeutic recommendations and be less satisfied with their health care experience.

Although little empirical attention has been given to African American patients'
perceptions of their providers' cultural sensitivity and competence, there is evidence that
cultural differences between patients and practitioners, particularly in the interpersonal
and communicative quality of care provided to such patients, may hinder the health
outcomes patients experience (Hall, Roter, & Katz, 1988). For instance, Safran et al.
(1998) reported that factors including patient-physician communication, interpersonal
treatment, knowledge of the patient, and the patient's trust in their physician were all
positively associated with health care outcomes including adherence to medical
regimens, patient satisfaction, and improvement in health status. In fact, empirical results
have showed that patients' perceptions of the interpersonal and communicative manner
in which their health care is provided is often the aspect of care that patients are less
satisfied with and that accounts for the greatest variation in patient satisfaction (Aharony
& Strasser, 1993, Hall et al., 1988; Stewart et al., 2000).

Many investigations have focused on issues regarding the doctor-patient relationship among African American and other ethnic minority patients. For instance, several studies in the literature have reported that African American patients may be at a disadvantage, relative to Caucasian patients, when it comes to the quantity and quality of information they receive from their health care providers. Research has showed that African American patients receive less or inadequate health care information from their health care providers, despite reports that such patients desire more information than they receive and they ask fewer questions (Davis, Brown, Allen, Davis, & Waldron, 1995; Kogan, Kotelchuck, Alexander, & Johnson, 1994; Pierce, 1997; Stewart et al., 1999). For instance, Kogan et al. (1994) reported that pregnant African American women were significantly less likely than Caucasian women to receive information about appropriate prenatal care. Such differences in information given may have implications for promoting positive health outcomes among African American patients given evidence that patient satisfaction is positively associated with information given (Hall et al., 1988).

Similarly, Gemson, Elinson, and Messeri (1988) performed a survey of over 120 health care providers and found that these health care providers were less likely to offer preventive care information and recommendations to Black and Hispanic patients, relative to Caucasian patients, and spent less time with these ethnic minority patient group members. For instance, they found that health care providers recommended mammography screening to 23% of their Caucasian patients, but only to 7% of their Black and Hispanic patients. Such research is corroborated by additional evidence that African Americans are less likely to be appropriately referred for tertiary care procedures

such as cardiac catheterization and to be medically untreated, even when economical issues such as insurance and method of payment have been taken into account (Hall et al., 1988; Schulman et al., 1999; Weddington et al., 1992). These findings suggest that cultural bias in the form of prejudice and discrimination may exist on the part of health care providers. Such potential bias is significant not only because it may limit the types of recommendations and referrals that health providers make, but evidence has indicated that patients who perceive that they are being discriminated against are likely to be less adherent to prescribed regimens, to reject continuity of care, and to be dissatisfied with their health care (Stewart et al., 1999).

Further support for the proposition that cultural differences between African American patients and their health care providers may obstruct the quality of care and increase the dissatisfaction that such patients experience can be found in the literature regarding patient-physician communication patterns. Brookins (1993) reported that many ethnic minority patients including African Americans are dissatisfied with the health care that they receive and fail to comply with their health care provider's recommendations because the relationship is not egalitarian. That is, many African Americans may perceive themselves to be subservient to the perceived higher status "doctor." Such perceptions may often set up the scenario wherein patients feel unempowered in their relationship with their health care provider. Indeed, it has been reported that many culturally different patients are reluctant to bring to their physician's attention any concerns that they may have regarding discrepancies between their cultural perspective and the health practices of their physicians (e.g., patients fear that such

discussion may insult their physicians, compromise their quality of care, and/or that their beliefs may be subject to ridicule, etc.) (Thompson, Thompson, & House, 1990).

Research has also showed that when physicians make unilateral decisions about ethnic minority patients' therapeutic regimens, or fail to elicit their patients' cultural and psychosocial concerns, culturally different patients are less likely to comply with recommendations, be more dissatisfied, and experience worse health outcomes (Hall et al., 1988; Rohrbaugh & Rogers, 1994; Roter et al., 1997; Stewart et al., 1999). For instance, meta-analytic results reported by Hall et al. (1988) showed that partnership-building (i.e., having health providers assume a less dominant role and elicit more patient input) was positively associated with patient satisfaction. Similarly, Roter et al. (1997) found that physicians were more prone to focus on the biomedical as opposed to the psychosocial aspects of their patients' illness, especially when the patients were Black and of lower income. Not surprisingly, such biomedical emphasis in the patient-physician interactions was associated with less satisfaction reported by such patients. These findings are unfortunate because not only do they indicate that physicians may be less likely to attend to their patients' cultural perceptions of their illness, but they may provide less educationally or culturally appropriate feedback to patient populations who may need it the most.

The preceding research coincides with evidence that the most common physician-patient relationship currently in medical practice is the traditional "doctor-centered" approach (Ong, DeHaes, Hoos, & Lammes, 1995). Such a relationship is characterized by the doctor being the "expert" and in control of the communication exchange between patient and physician. Such a relationship is in contrast to the

"patient-centered" approach that is more egalitarian and includes more mutual communicative exchange. Given the current prevalence of the traditional "doctor-centered" health care approach, culturally different patients may be at a disadvantage on account that health care providers may be less likely to inquire about these patients' culture-related perceptions of their medical condition and health care practices. The "doctor-centered" health care approach may also jeopardize physicians' understanding of the cultural views of their African American patients given the lack of reciprocal exchange associated with this approach. The "doctor-centered" approach and its potential insensitivity to patients' culture can have detrimental health consequences for patients. Research has showed that patients who perceive that their providers are not meeting their health care expectations or are unresponsive to their concerns are less likely to adhere to therapy and are more likely to be dissatisfied with their health care (Stewart et al., 1999).

Research with ethnic minority group members has also suggested that the communication difficulties between such persons and their health care providers may be exacerbated when language differences are apparent between patient and health provider. Language concordance between patients and their health care providers has been found to be associated with more information sharing and greater patient satisfaction (Perez-Stable, Napoles-Springer, Miramontes, 1997). Moreover, patients' misunderstanding of instructions from physicians has been suggested as being the most important reason for noncompliance with medical regimens (Lieberman et al., 1997). Although one may assume that language barriers are not as much an issue for African Americans since most are English-speaking, this assumption may be inaccurate for African American patients

who are prone to speak "Black English." Under circumstances in which there are differences in the vernacular between African American patients and their health care providers, providers and patients may be susceptible to miscommunication (Carter, 1995).

Cultural differences in nonverbal communication between African American patients and their health care providers may also jeopardize the quality of care such patients experience. It has been reported that patients are very sensitive to and observant of the nonverbal behavioral exchanges with their health care providers (Ong et al., 1995). This may be particularly true of African American patients, who may have a greater distrust of the health care system compared to Caucasian Americans (Carter, 1995; Davis et al., 1995). Moreover, research has shown that ethnic minority groups including African Americans may exhibit and prefer nonverbal patient-physician communication patterns that are different from those exhibited by Caucasian Americans (Carter, 1995; Lieberman et al., 1997). For instance, African American patients may prefer nonverbal behaviors such as less eye contact from physicians while listening, being physically touched by their provider, and having their provider sit or stand proximal to them. Given that ethnic groups, including African Americans, differ in the types of nonverbal forms of communication that they exhibit and prefer, it is important for health care providers to be sensitive to these differences in nonverbal communication preferences across ethnic groups. In addition, health care providers must remain aware that African American patients are less inclined to ask questions. Accordingly, additional question asking on the part of health care providers may be appropriate and necessary. Health care providers' awareness of these nonverbal communication preferences among

African Americans may help them to enhance the rapport and communication they have with their African American patients (Lieberman et al., 1997).

Corroborating the notion that differences in behavioral patterns between health care providers and their non-majority patients may affect patients' health outcomes is recent research by Pedersen and Tucker (2000). Their investigation, which involved African American and Caucasian American pediatric renal patients, indicated that level of comfort with and trust in one's health care provider was positively associated with African Americans' self-reported medication adherence. Moreover, they found that African American patients belief that God or the Holy Spirit helps one take her or his medication was also positively associated with self-reported levels of medication adherence. These findings indicate that issues which facilitate African American patients' trust in their health care provider, including that their culture-related health care practices and preferences are to be respected, may be important parameters in the provision of culturally sensitive health care to such ethnic minority patients.

It has likewise been suggested that health care environment variables may effect ethnic minority patients' perceptions of the quality of their care and subsequent health outcomes. For instance, issues such as the office environment can have an adverse affect on the patient-physician relationship if items in the office (e.g., paintings, books, etc.) may be construed by patients as insulting to their culture (Kune-Karrer & Taylor, 1995). Similarly, Mokuau and Fong (1994) have indicated that decorating and incorporating diverse culturally appropriate material (e.g., music) within the health care environment may increase ethnic minority patients' perceptions of the acceptability of such health

services. Greater acceptability may presumably lead to greater health care satisfaction and better health outcomes.

The above evidence suggests that cultural differences between African American patients and their health care providers may impact the quality of care and health outcomes such persons experience. The purpose of the present investigation is to be the first known empirical effort to directly evaluate the level of association between African American Veteran outpatients' perceived cultural sensitivity in health care received and reported level of satisfaction with the health care that they received.

Cultural Sensitivity and Patients' Sociodemographic Characteristics

Patient characteristics such as age and education level have been empirically examined in relation to communication patterns that patients have with their health care providers. The meta-analytic study by Hall et al. (1988) showed that older patients tend to be treated more courteously by health care providers, receive more information, and engage in more total communication than younger patients. Moreover, Roter et al. (1997) reported that older patients were more likely to have communication with their physicians that focused more on the biomedical aspects of their condition than psychosocial issues. It is plausible that the lack of psychosocial emphasis may include lesser attention and communication devoted to patients' cultural views. Unfortunately, research devoted to whether cultural sensitivity and differences in the provision of health care for older versus younger African Americans is sorely lacking.

It has been suggested that although African Americans expect their health care providers to be open and willing to listen, older African Americans may prefer more unilateral, doctor-centered patient-physician relationships. Specifically, given that older

African Americans have had to adapt to societal institutions that have historically been authoritarian and discriminatory towards them, it has been proposed that elder African Americans may be less likely to adopt or desire a collegial relationship with non-African American physicians (Mouton, 1997). Accordingly, the manner in which African American patients may perceive their health care providers as culturally sensitive, as a function of the patient's age, is a topic in need of investigation.

Existing research also shows that physicians provide more information, spend more time, and have better communication with patients of higher education and social class (Hall et al., 1988; Levy, 1985). For instance, Stewart et al. (1999) reported that (a) physicians underestimate poorly educated and impoverished patients' desire for information, (b) poorly educated patients tend to be more reticent in their patient-physician interactions, and (c) health care providers tend to provide less information about the condition and prognosis to poorly educated and economically impoverished patients. Such results corroborate findings that more highly educated patients receive higher quality of care (both technically and interpersonally), a finding that may be associated with physician reports of more interest and less frustration in treating such patients. These results portray a dismal picture for African American health care consumers who are less educated. Such patients may be at greater risk of receiving health care that is not respectful and that does not take into account their cultural differences with their health care providers. Given that cultural differences may be associated with more negative health outcomes, the relationship between African American patients' perceptions of their health care providers' cultural sensitivity and these patients' age and education level will be assessed in the present investigation.

Acculturation

Acculturation may be best described as the "extent to which ethnic minorities participate in the cultural traditions, values, beliefs, and practices of their own culture versus that of the dominant 'White' culture" (Landrine & Klonoff, 1996). Ethnic minority persons vary in the degree of their level of acculturation. Those persons who strongly endorse and identify with their own ethnic culture are referred to as "traditional;" those who endorse and identify with the "White" dominant culture are considered as "acculturated;" and those who identify and endorse the values and practices of both their own culture as well as that of the "White" dominant society are deemed to be "bicultural." These distinctions in the degree that ethnic minority persons assimilate (if at all) to the core culture provides a backdrop for better understanding ethnic differences. Specifically, the concept of acculturation provides a theoretical framework regarding the relationship between culture and behavior.

Ethnic minority persons who are highly traditional as opposed to acculturated tend to possess cognitive styles and behave in ways that are quite dissimilar from their more acculturated ethnic peers. Acculturated ethnic minority persons, in contrast, are more apt to be similar to Whites across a number of scales and behaviors (Dana, 1993). For instance, whereas traditional ethnic minorities tend to rely on family and kin for social support, acculturated ethnic minority persons are more prone to rely on friends and coworkers during times of distress (Landrine & Klonoff, 1996).

In order to further examine the issue of acculturation, investigators have developed acculturation scales for specific ethnic populations including Mexican Americans (Cuellar, Arnold, & Maldonado, 1995; Mendoza, 1989), Cuban Americans

(Szapocznik & Kurtines, 1980), Japanese Americans (Masuda, Matsumoto, & Meredith, 1970), Chinese Americans (Yao, 1979), and Native Americans (Hoffman, Dana, & Bolton, 1985). These scales have been used in a number of studies that have investigated the relationship between culture and a number of health-related behavioral indices. For example, investigations have found a positive association between ethnic minority members' level of acculturation and coronary heart disease (Sundquist & Winkleby, 1999), and a negative association between ethnic minority members' level of acculturation and substance abuse (Garcia, 1999), hypertension and smoking (Landrine & Klonoff, 1996).

Despite the significant implications the concept of acculturation has for predicting ethnic differences in behavior, this concept has gone largely ignored with regard to African Americans. Psychology and the health-related professions have largely ignored the traditions, practices, and beliefs that many African Americans possess. It has often been considered that the culture of African Americans in the United States was destroyed via slavery. Unfortunately, psychology and similar fields have corroborated such presumptions by way of focusing theories and investigations on racial (physical criteria/aspects) as opposed to ethnic (cultural criteria/aspects) attributes (Landrine & Klonoff, 1996). Although exploring racial differences between "Blacks" and "Whites" has historically provided a great deal of information about the discrepant standards of living between these races, such investigations have been limited in that they typically have placed African Americans in a negative and disadvantaged perspective (Oyemade & Rosser, 1980). Moreover, an accurate understanding of the values, practices, and traditions (i.e., culture) of African Americans and the role such factors play in the

reported differences between Caucasian Americans and African Americans, and among African Americans themselves, has largely gone ignored.

Only recently has an acculturation measure for African Americans been developed (see Landrine & Klonoff, 1995; 1996). Research into the development of this measure (the African American Acculturation Scale; AAAS) indeed showed that "traditional" African Americans differed from Caucasian Americans and "acculturated" African Americans along a number of dimensions including family practices, preference for African American things (e.g., friends, music, magazines, etc.), preferred foods, interracial mistrust, health beliefs and practices, religious beliefs and practices, socialization (i.e., during development participated in traditional African American activities), and superstitions. The development of such a scale has not only demonstrated the cultural heterogeneity of African Americans as a group, but has also provided a refreshing perspective of African Americans that is not solely attributable to race, skin color ("Black"), or other physical features. Such a measure holds great promise for increasing professionals' understanding of African Americans as a group, and their understanding of how one's level of acculturation may predict one's behaviors.

Acculturation and Health Outcomes/Patient Satisfaction

As previously mentioned, research has examined the role that ethnic minority members' level of acculturation may play in the health-related behaviors and outcomes such persons may experience. Much of this research has been conducted on ethnic minority groups other than African Americans. For example, Prislin, Suarez, Simspon, and Dyer (1998) reviewed research that reported that acculturation in Hispanic persons' was positively associated with greater infant mortality, inadequate immunization, the

prevalence of cancer, high blood pressure, adolescent pregnancy, health status via outpatient care, cancer screening among women, and self-protective sexual behavior. Similarly, Heilemann, Lee, Stinson, Koshar, and Goss (2000) reported that greater acculturation among Mexican American women was associated with greater weight gain, greater risk for sexually transmitted diseases, use of alcohol and drugs, and complications associated with childbirth.

Although the above findings suggest that greater acculturation among Hispanic Americans may be associated with more negative health outcomes, other research has shown that greater acculturation among such persons is associated with improved prenatal and outpatient care (Alcalay, 1992), cancer screening among Mexican-American women (Suarez, 1994), and self-protective sexual behavior in Hispanic unmarried adults (Marin, Tschann, Gomez, & Kegeles, 1993). In addition, Landrine, Richardson, Klonoff, and Flay (1994) conducted a study involving over 4,000 Latino adolescents in order to examine the potential relationship between acculturation level and cigarette smoking among such youths. Results showed a strong, linear relationship wherein acculturated Latino youths smoked the most and traditional Latino youths smoked the least.

The role that acculturation may play in moderating health behaviors such as medication adherence has also been investigated. Pachter and Weller (1993) evaluated the acculturation level of Puerto Rican families of children with asthma. They reported that children of more acculturated families were more likely to be compliant to their medication regimen than children from less acculturated families. Such results suggest that greater congruence in cultural orientation between more acculturated families and

the medical establishment may facilitate greater adherence and satisfaction among such patients and their families.

Research that has explored differences in the level of acculturation of African Americans with respect to health issues has demonstrated that level of acculturation may indeed predict health behaviors/status. For example, research has shown that level of acculturation in African American women may be associated with risky sexual behavior, and that more traditional African American women may be at greater risk to be heavier drinkers (Hines, Snowden, & Graves, 1998). Similarly, Landrine and Klonoff (1996) conducted a study to evaluate the relationship between acculturation level among African Americans and smoking, the most preventable cause of death and a major causative agent in heart disease, hypertension, and cardiovascular disease (United States Department of Health, Education, and Welfare, 1979; Centers for Disease Control, 1989). Results showed that smokers were less acculturated than nonsmokers. In fact, smokers endorsed significantly more 'traditional' attributes than nonsmokers on subscales measuring health beliefs, cultural superstitions, and distrust of Whites. These findings suggest that African American smokers are not only more likely to be less acculturated than their nonsmoking peers, but that they may smoke as a result of their distrust of information about smoking provided by Whites and/or their beliefs that they are impervious to the consequences of smoking because of their superstitious rituals and health beliefs (pp. 94).

In addition to the above investigation, Landrine and Klonoff (1996) also empirically examined the relationship between level of acculturation and hypertension. Using African American patients both with and without hypertension, these investigators

determined that hypertensive patients endorsed a more 'traditional' level of acculturation while normotensives' scores on the AAAS reflected greater acculturation. Moreover, hypertensives scored particularly higher than their more acculturated normotensive peers on the preferred foods subscale, indicating that more 'traditional' African Americans may be at greater risk for illness because of a greater preference for less healthy foods. Indeed, foods such as collard greens and fried chicken are high in salt content and are frequently found as a dietary preference for African Americans with hypertension (Polednak, 1989). If in fact such an assumption is accurate, these findings suggest that more "traditional" African Americans may be predisposed to neglect the nutritional recommendations of the primarily 'White' health care profession.

Although these preliminary investigations do indicate that persons who endorse and more closely identify with more traditional African American practices, beliefs, and values may be at greater risk for poorer health status, understanding how level of acculturation is associated with such negative health outcomes is needed. Specifically, closer scrutiny of how African Americans' level of acculturation is associated with behavioral and outcome indices such as patient satisfaction may shed light on African American patients' health seeking behaviors. Cox (1986) compared physician utilization rates among Vietnamese, Portugese, and Hispanic elderly patients. Cox reported that Vietnamese patients, who were the least culturally assimilated of the other ethnic groups, were the least likely to use their physicians for medical assistance when they were dissatisfied with their health care. Such findings do suggest that acculturation may moderate the satisfaction that ethnic minority patients report and the potential health outcomes they experience. However, to date, no known investigations have directly

examined the relationship between patient satisfaction and patients' level of

acculturation. This is one of the foci of the present investigation with African American

patients.

<u>Acculturation and the Perception of Cultural Sensitivity in Health Care Received</u>

The acculturation level of ethnic minority group members may be an important

intracultural variable for understanding how such persons perceive the cultural

sensitivity and quality of care that they receive from the medical establishment.

Specifically, it would be erroneous to assume that all persons from an ethnic minority

group are going to be dissatisfied or perceive their health care provider as culturally

insensitive to their health care beliefs and practices. Persons vary greatly in terms of their

intracultural beliefs, values, and traditions. Such diversity, represented in the

individual's level of acculturation, may serve as a useful framework to explain why there

may be potential differences in satisfaction and perceived cultural sensitivity in health

care received among ethnic minority members. Specifically, if an individual identifies

with, adopts, and practices cultural behaviors that are different from those espoused by

the largely White-European health care system, it could be presumed that such persons

may be at greater risk of perceiving their health care experiences as more culturally

insensitive and less satisfying, and thereby experience more negative health outcomes

(Pachter & Weller, 1993). Indeed, the issue of receiving culturally sensitive health care

may be most important for persons whose own cultural orientation is most different (i.e.,

less acculturated) from the majority of health care providers.

Anderson (1991) suggested that persons from a traditional, Afrocentric

perspective are likely to share values of African heritage such as spirituality, a

group/family focus, social responsiveness, and emotional expressiveness. Persons who adopt a more traditional, Afrocentric perspective may accordingly possess beliefs and values that may conflict with the prevalent health care model in the United States (i.e., largely based on "White" values and customs), with its often fast-paced, high patient volume health care encounters (Jones & Bond, 1999). The conflict between the traditional, Afrocentric beliefs of patients and the pull to conform to the diagnoses and recommendations of the American medical establishment may not only create greater stress for traditional African Americans, but such stress may foster a social pattern of alienation from the health care establishment (Anderson, 1991).

Huff and Kline (1999) have argued that the provision of culturally sensitive health care and the assessment of acculturation among culturally diverse patients should be pursued because patients may have a tendency to resist acculturation. Such resistance can lead to misunderstandings between patients and physicians, limit the effectiveness of the therapeutic alliance, and set the stage for culturally diverse patients to be at greater risk for negative health behaviors and outcomes. Indeed, it has been proposed that less acculturated African American women may be at risk for AIDS transmission because of mistrust of AIDS prevention messages provided by American health care professionals (Hines, Snowden, & Graves, 1998). Reports of effective AIDS education and prevention programs for African Americans by increasing family involvement (a characteristic of Afrocentric heritage) may be indicative of a culturally sensitive approach to facilitating AIDS awareness, particularly among less acculturated African Americans (Klonoff & Landrine, 1999).

It has also been suggested in the literature that acculturation may play a role in the degree of effective communication between culturally diverse patients and their health care providers. Specifically, Gonzalez-Lee and Simon (1987) describe a program for enhancing the cross-cultural sensitivity of medical students. These authors propose that members of ethnic minority groups who vary in their level of acculturation may accordingly vary in the way they perceive and react to their health care providers and their providers' recommendations. They propose that acculturation differences may affect patients' understanding of their illness as well as their compliance to medical recommendations. Such propositions are in concert with literature suggesting that discrepant models of health and illness between patients and their physicians may limit the effectiveness of physician-patient communication during the clinical encounter (Pachter, 1994). Ethnic minority group members who are less acculturated are more likely to have beliefs and values that include culture-specific explanatory models of health and illness (i.e., "folk illnesses") and that may differ from their more acculturated peers. Moreover, such culturally different models of health and illness among less acculturated persons may not fit well into any biomedical disease category. Physicians who do not acknowledge this incongruence in models of health and illness or who do not attempt to sensitively address this incongruence in the course of the clinical encounter could jeopardize the understanding, communication, and therapeutic benefit less acculturated patients could experience.

It has been proposed that having health care providers who are able to acknowledge and embrace both the cultural orientation of the medical profession as well as the cultural heritage of their culturally diverse patients could significantly minimize

less acculturated patients' dissonance and reactivity in health care encounters. Such cultural sensitivity and competence may facilitate health care providers' treatment of their patients by allowing the biomedical profession to be viewed as "complementing" rather than competing with the traditions and beliefs of less acculturated persons (Brookins, 1993). Unfortunately, despite the numerous propositions of a link between patient level of acculturation and health care providers' provision of culturally sensitive health care, no empirical investigations have been performed on this topic to date.

Accordingly, the purpose of the present investigation is to examine the association of African American patients' level of acculturation with their perceptions of how culturally sensitive they perceive their health care to be. Results could not only help determine the role that acculturation may play in patients' perceptions of their health care providers' quality of care, but could increase health care providers' awareness of what important variables may affect their ability to provide culturally sensitive care and facilitate healthier behaviors and outcomes in their African American patients.

Acculturation and Patient Sociodemographic Characteristics

Several investigations have indicated that acculturation is often confounded with socioeconomic status and covaries with a host of demographic variables (Prislin et al., 1998; Snowden & Hines, 1999). For instance, in their effort to develop an acculturation scale for African Americans, Snowden and Hines (1999) reported that African Americans' acculturation was positively associated with their level of income, education, likelihood of divorce, and urban residence, and negatively associated with religious affiliation.

In addition to these demographic variables, research reviewed by Anderson (1991) has provided some evidence for greater acculturation among younger African Americans. Specifically, children and adolescent African Americans may be more apt to initially identify with Anglo-American values. However, as they age and become increasingly aware of racial and cultural differences, their preference for and identification with Afrocentric beliefs and traditions may increase.

In as much as the issue of acculturation has been found in prior investigations to covary with various demographic and status variables, other research has found this not to be the case. Specifically, in their efforts to evaluate the validity of the African American Acculturation Scale (AAAS), Landrine and Klonoff (1994) proposed that acculturation should reflect the degree to which individuals are immersed in their culture of origin, irrespective of status variables. Indeed, their research showed that factors such as African Americans' education level, income level, or gender did not predict level of acculturation. Moreover, cross-validation of the AAAS with a separate sample of 175 African American adults who were significantly older than those used in the original validation of the AAAS revealed no significant differences in level of acculturation as a function of age (Landrine & Klonoff, 1995). These findings suggest that sociodemographic characteristics such as income level, education level, gender, and age may not be associated with African Americans' level of acculturation as had been reported elsewhere (i.e., Snowden & Hines, 1999).

Given that the study and measurement of acculturation among African Americans has only recently begun to garner empirical attention, further evaluation of whether demographic variables reliably covary with African Americans' level of

acculturation deserves further consideration. Moreover, should the present investigation fail to find an association between patients' sociodemographic characteristics and their level of acculturation, such findings would provide support for the construct of acculturation and its potential effect on other parameters (i.e., patient satisfaction, perceived cultural sensitivity) independent of sociodemographic characteristics of the patient. Accordingly, determining whether African American patients' age and education level are associated with their level of acculturation will be another research question that will be evaluated in the present investigation.

<u>Health Care Providers' Demographic Variables and Patient Satisfaction and Perceived Cultural Sensitivity</u>

Although considerable empirical attention has been given to the role that patients' demographic characteristics may play in the health-related behaviors and outcomes that patients experience, far less attention has been given to the role of physician demographic characteristics. This is unfortunate given evidence that African American health care consumers are more likely to seek health care providers that are ethnically similar to themselves (Gray & Stoddard, 1997). Such tendencies not only suggest that health care providers' demographic characteristics (e.g., gender, ethnicity, etc.) may play a role in patients' health seeking behaviors, but such variables could potentially be associated with patients' satisfaction and perceptions of how culturally sensitive their health care encounters are.

Murphy-Cullen and Larsen (1984) directly investigated patients' and physicians' sociodemographic characteristics and their interactions as factors in patient satisfaction with health care received. Results from their analyses of 19 family physicians and 217

outpatients indicated that the only physician demographic variable that affected patients'
satisfaction was age. Specifically, patients reported greater satisfaction with health care
from younger physicians as opposed to older physicians. Moreover, physicians' gender,
marital status, or ethnicity had no effect on patient satisfaction. These findings have been
supported by more recent research which has failed to find a difference in patient
satisfaction as a function of their health care providers' gender (Gross, Zyzanski,
Borawski, Cebul, & Stange, 1998).

In as much as the preceding findings indicate little relationship between
physician demographic characteristics and the satisfaction with health care that their
patients report, other research suggests that physician characteristics may have an effect
when they match those of their patients. Specifically, Pascoe (1983) reviewed research
on physicians who possessed non-normative sociodemographic characteristics. Results
showed that patients of such physicians were likely to report greater satisfaction when
their own sociodemographic characteristics were similar to those of their non-normative
physicians. Such findings allow for speculation that ethnic minority patients may report
greater satisfaction when their providers are of a similar ethnic minority status.

In addition to patient satisfaction with health care received, the role that
physicians' demographic characteristics may play in patients' perceptions of the degree
to which they receive culturally sensitive health care merits consideration. Although
there is no known research that has examined this directly, evidence from the patient-
physician communication literature has shown that physician demographic
characteristics may influence their communication patterns with their patients. For
instance, Barnsley, Williams, Cockerill, and Tanner (1999) reported that female

physicians are more empathetic in their communication with patients, less directive, and spent considerable more time discussing patients' lifestyles with them during their initial visit. Such findings point to the possibility that female health care providers may be more apt to attend to cultural issues in the patient-physician relationship.

Likewise, research has shown that physician ethnicity and language spoken are characteristics that affect the quality of communication between physicians and their patients. Empirical evidence has indicated that physician-patient concordance in ethnicity and language spoken may significantly contribute to more information sharing, perceptions of greater participation by patients during office visits, better patient appointment keeping, and better health status and outcomes (Cooper-Patrick et al.., 1999; Perez-Stable et al., 1997; Stewart et. al., 1999.). In contrast, research has indicated that there is an increased risk of racism and prejudice in the patient-physician relationship when physicians' sociodemographic characteristics, particularly ethnicity, differ from those of their patients (Levy, 1985).

These findings collectively show that physician demographic characteristics such as gender and ethnicity may have an effect on the quality of the patient-physician encounter and the communication that takes place. Given the importance of discussing and considering cultural differences between physicians and ethnically different patients in the provision of health care, these findings suggest that ethnic minority persons may be at risk of perceiving their health care as less culturally sensitive when their health care providers' are male or ethnically different from themselves. The current investigation will attempt to evaluate this issue directly by examining the relationship between African

American patients' perceptions of how culturally sensitive the health care that they receive is and their health care providers' gender and ethnicity.

<center>Health Care and African American Veteran Patients</center>

The main impetus of the present investigation is the increasing growth of ethnic minority groups, including African Americans, and the need for health care institutions to be able to provide culturally sensitive health care to these potential patients. This call for health care providers to be more culturally sensitive may hold particularly true for those institutions, such as the Veterans Administration (VA), that are more likely to care for the ever-increasing number of African American veterans and African American active duty personnel in the United States armed forces. Although 1990 census data showed that only 8.6% of veterans were African American, current projections are that African Americans comprise nearly 20% of active duty personnel in the United States armed forces (VA Office of Program and Data Analyses, 2000). Given recent estimates by the United States Bureau of Census (2000) that African Americans account for approximately 13% of the entire United States population, the preceding armed forces data suggest that African Americans have increasingly become over-represented among the United States armed forces. These data suggest that health care institutions such as the VA should be prepared to provide health care for a higher proportion of African Americans in the veteran population.

The Veterans Administration (VA) is one of the largest health care systems in the United States, with numerous health care centers and clinics available nationwide to serve over 23 million American Veterans (Lefkowitz, Snow, & Cadigan, 1990; VA Office of Program and Data Analyses, 2000). Unlike other health care systems in the

United States, the VA is a federally financed and administered health care delivery system for eligible veterans. Many veterans with service-connected disabilities and socioeconomic need are eligible to receive services in the VA health care system at no cost or for a co-pay. Receiving health care at the VA offers an advantage for veterans, compared to non-veterans who receive care through private or community health care agencies, by way of minimizing the costs that they would have to incur. Moreover, the economic advantages of pursuing health care services at the VA may be especially significant to veterans, including African American veterans, because they are more than twice as likely than non-veterans to lack health insurance (VA Office of Program and Data Analyses, 2000).

Although many veterans have the ability to receive affordable health care services through the VA, data has indicated that African American veterans may be prone to underuse health care services much like African-American non-veterans. For instance, Rosenheck et al. (1995) reported that black veterans suffering from Posttraumatic Stress Disorder (PTSD) were likely to attend fewer mental health sessions than white veterans with PTSD. Similarly, in a nationwide study of VA Medical Centers, research on cardiac diseased patients showed that Caucasian veterans were significantly more likely to receive invasive cardiovascular procedures (e.g., cardiac catheterization, coronary angioplasty, and coronary artery bypass grafting) than African American veteran patients (Whittle, Conigliaro, Good, & Lofgren. 1993). Results of these investigations are significant because neither Caucasian veterans nor African American veterans were required to pay for the health care services (i.e., mental health services, cardiovascular procedures) that they were eligible to receive in these

investigations. Accordingly, it is unlikely that issues such as financial availability or access to health care accounted for the racial differences in veterans' health care use reported in these investigations. Rather, it is suggested that cultural differences in health care attitudes between patients and physicians or systematic racial bias against African American veterans may account for these racial differences in veterans' use of VA health care services (Whittle et al., 1993).

Research has also shown that African American veterans may be prone to underuse preventive care opportunities and be noncompliant to medical regimens. For instance, Lefkowitz, Snow, and Cadigan (1990) examined veterans' adherence to recommended preventive health care at a VA Primary Care Clinic. In a random sample of over 1,000 veteran patients, these authors reported that black veterans were significantly less likely than white veterans to comply with their providers' recommendations to use influenza vaccination preventive care. Likewise, Sharkness & Snow (1992) investigated the pharmacy compliance of 93 black veterans and 32 white veterans receiving outpatient care at a VA Hypertension Clinic. Although results of compliance indices were not consistently associated with factors such as the veteran's age, sex, education, income, intelligence, marital status, or knowledge of the disease process, the veterans' race was significantly associated with refill rates. Specifically, results showed that white veterans were more likely to comply with their medication regimen than black veterans.

Also, consistent with research on patient satisfaction in health care received by non-veterans, research has suggested that African American veterans may be at greater risk than Caucasian veterans to be dissatisfied with their health care. Young et al. (2000)

reported in a nationwide survey of over 34,000 veteran patients receiving care at the VA that factors such as race, age, and health status were the most consistently important determinants of patients' satisfaction with health care received. Specifically, veteran patients who were older, of better health status, and Caucasian (as opposed to non-Caucasian) were significantly associated with higher satisfaction scores with health care received. These findings were consistent for veteran patients receiving inpatient and outpatient health care services.

Collectively, the research on African American veterans and the health care that they receive appears to be consistent with research on African American non-veterans' health care experiences. Specifically, African American veterans tend to underuse health care services, tend to be more noncompliant with therapeutic recommendations, and tend to be more dissatisfied with their health care relative to Caucasian veterans. Given the economic parity in access to health care services offered by the VA to Caucasian veterans and African American veterans, it is unlikely that financial differences in access to health care delivery can account for the racial differences in health care use, compliance, and satisfaction with health care reported. Alternative explanations including, but not limited to, cultural differences between African American veterans and their health care providers may account for African American veterans' underuse, greater noncompliance, and greater dissatisfaction with health care received.

It has been suggested that African American veterans' underuse, greater noncompliance, and greater dissatisfaction with VA health care services may be due to cultural differences between health care providers and veteran patients in attitudes toward medical care, as well as systematic racial bias on the part of VA health care

providers (Lefkowitz, Snow, & Cadigan, 1990; Whittle et al., 1993; Young et al., 2000).

Moreover, it has been proposed that some African American veterans' underuse of

health care services may in part stem from maltreatment by the military and resultant

distrust for governmental institutions including the VA. It has been reported that black

and Hispanic members of the United States armed forces have been more likely to

experience negative effects (e.g., discrimination) from their military service than whites

(Rosenheck & Fontana, 1994). For example, many accounts have been documented that

African American veterans were more likely to be treated harshly during their tours of

duty in Vietnam and Korea than Caucasian members of the armed forces (Rosenheck et

al., 1995). These findings are corroborated by data that has indicated that African

American veterans were over 50% more likely than Caucasian veterans to suffer from

PTSD over a decade after the Vietnam war (Kulka et al., 1990). It is believed that such

emotionally painful experiences may have alienated many African American veterans in

the form of distrust for the government and its institutions including the VA.

Unfortunately, as with African American non-veterans, there is a paucity of

research regarding the degree to which African American veteran patients trust, are

comfortable with, and perceive their health care providers to be culturally sensitive to

their ethnic values, beliefs, and practices. Moreover, research on how African American

veterans' perceived cultural sensitivity in health care received is associated with their

satisfaction with health care received, their level of acculturation, their demographic

characteristics, and the demographic characteristics of their health care provider is also

deserving. Given reports that African American veterans are often more reluctant than

Caucasian veterans to participate in health care research (Rosenheck, Wilson, &

Meterko, 1997), targeting African American veteran patients in the present investigation offers promise of acquiring invaluable information regarding these patients' perceptions of their health care experiences.

CHAPTER 3
METHODOLOGY

Participants

Participants in this study consisted of 106 African American male veterans (age 18 and over) who were recruited from the Department of Veterans Affairs Medical Center in Syracuse, New York. Only those African American veterans who received outpatient primary care services at this facility within the last 24 months were informed of this study by mail and were eligible to be contacted by telephone and invited to participate. Patients received 15 dollars in compensation for their participation and completion of a battery of questionnaires (the Health Care Battery - HCB).

The demographic characteristics of the participants are shown in Table 3-1. Patient participants' ages ranged from 34 to 84, with a mean age of 55 years old. In addition to the demographic characteristics presented in Table 3-1, participants reported a range of one to 200 health-related visits to the Syracuse VA Medical Center within the last 24 months ($\underline{M} = 17.2$, $\underline{SD} = 27.5$). The majority of participants identified their religious preference as Baptist (52.8%), while the remaining participants identified their religious affiliation as "other" (e.g., Lutheran, Protestant, etc.) (17.0%), no preference (9.4%), Catholic (7.5%), Methodist (7.5%), Presbyterian (2.8%), or Islamic (2.8%). Seventy-one participants (67.0%) reported that they did not have to pay or co-pay for their last primary care visit to the Syracuse VA Medical Center (i.e., the costs for their primary care visit were covered by their health insurance or VA benefits), while

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Table 3-1

Demographic Description of Patient Participants

Variable	Frequency	Percentage
Age of Participant:		
45 and younger	29	27.4
46 to 60	48	45.3
61 and older	29	27.4
Relationship Status:		
Single	27	25.5
Partnered	11	10.4
Married, living without a partner	8	7.5
Married, living with a partner	31	29.2
Divorced or legally separated	23	21.7
Widower	6	5.7
Paid Employment Status:		
Full-time	21	19.8
Part-time	5	4.7
Not employed	80	75.5
Highest Education Level Completed:		
Elementary School	3	2.8
Middle/Junior High School	7	6.6
High School	31	29.2
Some College/Technical School	43	40.6
College	20	18.9
Professional/Graduate School	2	1.9
Annual Household Income Level:		
Below $10,000	32	30.2
$10,001 - $20,000	38	35.8
$20,001 - $30,000	16	15.1
$30,001 - $40,000	12	11.3
Above $40,000	8	7.5

thirty-five participants (33.0%) reported having to pay directly for their medical services.

Seventeen participants (16.0%) self-reported that their overall health was "poor," fifty-

five participants (51.9%) reported that their overall health was "fair," thirty participants

(28.3%) reported that they were in "good" health, and four participants (3.8%) reported that their overall health was "excellent."

<div align="center">Instruments</div>

Each participant was asked to complete a Health Care Battery (HCB), which included the following inventories: a Demographic Data Questionnaire (DDQ), the African American Acculturation Scale–Revised (AAAS–R), the Patient Satisfaction Questionnaire Short-Form (PSQ-18), the Marlowe-Crowne Social Desirability Scale–Short Form [M-C (20)], and the Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA).

The Demographic Data Questionnaire (DDQ) was used to acquire information about the participant's age, gender, race/ethnicity, marital status, employment status, level of education, income, religious affiliation, perceived health status, and number of visits to the hospital within the last 24 months. Patients were also asked to report their health care provider's ethnicity and gender (Appendix A).

The African American Acculturation Scale–Revised (AAAS–R) developed by Klonoff & Landrine (2000) was administered to African American participants in the present investigation (Appendix B). The AAAS–R is a revised version of the original 74-item African American Acculturation Scale (AAAS) developed by Landrine and Klonoff (1994, 1996). The AAAS–R is a questionnaire designed to measure African Americans' cultural beliefs, values, traditions, and practices relative to the dominant White culture and consists of the following subscales:

- Preference for things African American
- Religious beliefs and practices
- Health beliefs and practices

- Racial segregation
- Cultural superstitions
- Interracial attitudes
- Family values
- Family practices

Original item content of the AAAS was derived from theory and developed using a sample that consisted of 123 African Americans, 37 Caucasian Americans, 13 Latino Americans, and 10 Asian Americans from diverse geographic, religious, and socioeconomic backgrounds. The AAAS–R is regarded as an improvement from the original AAAS because of its omission of 26 items that participants in previous research had identified as objectionable or insensitive. The final version of the 47-item AAAS–R and its subscales were derived from factor analyses performed on the remaining items of the original AAAS and developed from a different sample of 520 African American respondents (Klonoff & Landrine, 2000).

Concurrent validity of the AAAS–R was obtained by research that showed that African Americans who are exposed to African American culture regularly and frequently (i.e., more traditional) scored higher than those African Americans who are exposed to the culture less often (i.e., more acculturated, live in White or integrated neighborhoods). These group differences were also substantiated on all of the empirically derived subscales. Group differences validity was also ascertained by comparing a sample of African Americans to a sample of members of other ethnic groups (Whites, Latinos, Asians). African Americans scored higher than the combined sample of other ethnic group members in total AAAS–R score and in all of the empirically derived 8 subscales (Klonoff & Landrine, 2000).

In terms of reliability, the AAAS–R correlated nearly perfectly with the original AAAS, r = .97. The overall split-half reliability of the AAAS–R was r = .79, and its internal consistency reliability was high r = .93. Moreover, each of the subscales of the AAAS–R showed evidence of high internal consistency reliability r = .67 to r = .89.

Items on the AAAS–R are rated on a 1-7 scale with 1 = "I totally disagree - Not true at all" and 7 = "I strongly agree - Absolutely true." The AAAS–R is a continuous scale and total scores were obtained by adding respondents' ratings across all 47 items. Participants' scores ranged from a low of 88 to a high of 299 out of a possible score of 329. The sample mean score was 207.12 and the standard deviation was 43.44. According to Klonoff and Landrine's (2000) validation study of the AAAS–R, African Americans scores ranged from 103 to 329, with a mean score of 220.46 and a standard deviation of 40.88.

According to Klonoff and Landrine (2000), higher scores on the AAAS–R indicate that a person is highly traditional, whereas lower scores are indicative of persons being more acculturated. The AAAS–R cannot adequately evaluate African American persons' biculturalism, multiculturalism, or the meaning of midrange scores on the scale (Landrine & Klonoff, 1996). In order to do so, the authors of the AAAS–R recommend comparing scores on the AAAS–R to participants scores on an instrument that measured European American culture. It is believed that individuals who scored equally high on both a European acculturation scale and the AAAS–R could be classified as bicultural, and those who scored low on both measures would be classified as marginal. Unfortunately, the development of a scale that appropriately measures European American culture is lacking.

The Patient Satisfaction Questionnaire Short-Form (PSQ-18), is a self-administered survey that measures patients' attitudes toward characteristics of doctors, medical care services, and general satisfaction with health care (Marshall & Hays, 1994; Ware et al., 1983; Appendix C). The initial version of the Patient Satisfaction Questionnaire (PSQ) was developed by Ware and colleagues (Ware, Snyder, & Wright, 1976a, 1976b) and consisted of 80 items to assess health services delivery programs as evaluated by the general public. It was standardized using four independent field tests, with sample sizes ranging from 323 to 640 persons, participant samples ranging from 3% nonwhite to 90% nonwhite, and varying socioeconomic and educational backgrounds among participants. Subsequent revision led to the PSQ-II, a 68-item questionnaire that has been used in national surveys and in the Rand Health Insurance Project (Marshall et al., 1993). More recently, the PSQ-III and its short-form, the PSQ-18, have been established to evaluate respondents' evaluations of the medical care that they receive (Marshall & Hays, 1994; Marshall et al., 1993; Wilkin, Hallam, & Doggett, 1992). The PSQ-III and its short form (PSQ-18) consist of 51-items and 18-items, respectively. The PSQ-III and PSQ-18 were developed on over 2,200 patients as part of the Medical Outcomes Study, and patients' demographic characteristics were proportionally representative of the United States population.

Marshall and Hays (1994) reported that the most recent versions of the PSQ consists of several dimensions or subscales:

- General satisfaction
- Technical quality (competence)
- Interpersonal manner
- Communication
- Financial aspects

- Time spent with doctor
- Accessibility and convenience

Van Campen et al. (1995) reported a meta-analysis of 221 patient satisfaction studies that used a variety of patient satisfaction measures. They concluded that the most frequently yielded dimensions of patient satisfaction in these studies was best covered by the taxonomy of the PSQ. In fact, the PSQ has been used in dozens of studies and all of its dimensions are in the top ten most investigated dimensions in patient satisfaction research (Hall & Dornan, 1988).

The PSQ-III and, its short-form, the PSQ-18 have been regarded as improvements on the PSQ and PSQ-II in terms of its item content across medical settings and its relevance to the respondent's own medical care experiences. Although much of the evidence on the psychometric characteristics of the PSQ relates to earlier versions of the PSQ, the PSQ-III and its short-form (PSQ-18) have been regarded as improvements in terms of its content validity and presentation relative to earlier versions of the PSQ (Wilkin, Hallam, & Doggett, 1992). Factor analysis and use of several multitrait-multimethod matrices, that have correlated the PSQ subscales and its global or general satisfaction scale with other satisfaction measures, have provided strong support for the convergent, discriminant, and construct validity of the PSQ subscales and its global satisfaction scale (see Ware et al., 1983).

In addition, the PSQ has been the most extensively studied measure of patient satisfaction in terms of its reliability (Ross et al., 1995). For instance, subscales of the PSQ-III have obtained internal consistency reliability rates from .82 to .89, with overall internal consistency of .89 (Marshall et al., 1993). Remarkably, the short-form of the PSQ-III, the PSQ-18, has been empirically proven to have retained many of the

psychometric characteristics of the full-length PSQ-III. With only one exception, correlations among subscales on the PSQ-18 and PSQ-III exceeded .90. In addition, patients' ratings on the PSQ-18 were remarkably similar across ethnic groups to those reported on the PSQ-III (Marshall & Hays, 1994), indicative of the short-form's utility with varied ethnic populations. These findings support the use of the PSQ-18 as a measure of patient satisfaction for circumstances in which brevity precludes administration of the entire PSQ-III, such as to enhance patient participation when multiple instruments are being used.

Relative to most patient satisfaction measures the PSQ has been deemed to be fairly resistant to an acquiescent response bias - a common methodological problem in patient satisfaction research (Ross et al., 1995). Scale items are rated from 1 = "Strongly Agree" to 5 = "Strongly Disagree," but the scale was constructed so that there would be both a number of positively and negatively worded items (i.e., thereby reducing the potential that participants would respond by always "agreeing" or always "disagreeing" with items).

Participants scores on the PSQ-18 scale of General Satisfaction were used as an index of general satisfaction with health care received in the present study. Previous research using structural equation modeling has shown that the PSQ measurement of patient satisfaction is consistent with a hierarchical model that taps both multifaceted aspects of health care delivery (i.e., its subscales) and a general domain of satisfaction that is highly correlated with the PSQ General Satisfaction scale (Marshall et al., 1993). Indeed, the inter-correlations between the General Satisfaction scale and 5 of the 6 subscales on the PSQ-18 in the current study ranged from .68 to .80 (the Financial

Aspects subscale correlated at .48). These inter-correlations are consistent with the inter-correlations reported by Marshall and Hays (1994).

Lower scores on the PSQ-18 are indicative of less satisfaction with health care received, while higher scores represent greater satisfaction with health care received. Participants scores on the General Satisfaction scale of the PSQ-18 ranged from 2.0 to 5.00, and the sample mean was 3.41, with a standard deviation of 0.77. This data indicates that the sample of participants in the current study were modestly satisfied with the health care that they received at the Syracuse VA Medical Center. This instrument is published by the RAND Corporation and is available for use without restriction.

The Marlowe-Crowne Social Desirability Scale–Short-Form [M-C (20); Crowne & Marlowe, 1964; Fraboni & Cooper, 1989] is a 20-item inventory that was used to measure the amount of variance in the data due to participants' desire to respond to questions in a socially desirable manner. The Marlowe-Crowne Social Desirability Scale (M-C SDS) originally consisted of 33 items which asked respondents to answer true or false to items such as "I gossip at times" or "I have played sick in order to get out of something." The short form [M-C (20)] is based on the original 33-item version of the M-C SDS and has been shown to be reliable using the Cadre-Richardson formula 20 (.78 for university males and .83 for university females). Pearson product-moment correlations between the short form and the original 33-item inventory were as high as .98, indicating adequate concurrent validity for the shorter form.

Sample scores on the M-C (20) ranged from a low of 4 to a high of 20 out of a possible 20. The sample mean was 12.94, and the sample standard deviation was 4.23.

The higher a respondent's score, the more likely they are responding in a socially desirable manner.

The Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA; Appendix D) is an instrument developed by Tucker et al. (2001) that was used in this study to quantitatively assess the degree to which African American patients perceive their health care providers and health care environments to be culturally sensitive. Items on the T-CUSCHI-AA were derived from focus group research reported by Pedersen (2000) and in conjunction with the more global "grass roots" investigation of culturally sensitive health care being conducted by Tucker et al. (2001). Their research is the first known to attempt to identify health care provider behaviors and health care environment issues that patients, not professionals, regard as culturally sensitive. Specifically, in the initial phase of their investigation, 51 African American patients were arbitrarily selected to participate from among several community primary care health clinics affiliated with the University of Florida and the North Florida Area Health Education Centers (NFAHEC) Program. Focus groups were conducted wherein African American participants were interviewed in small groups in order to obtain their feedback regarding their health care providers' (i.e., physician's) behaviors and health care environment variables that they perceived as culturally sensitive or insensitive. Specifically, focus group respondents identified numerous physician and staff behaviors and health care environment issues that were important in promoting patient trust, patient comfort, and in conveying awareness of and respect for patient's culture (i.e., cultural sensitivity) in their health care received (Pedersen, 2000). Two sets of research assistants condensed the interview data into culturally sensitive

non-redundant behaviors and health care environment variables for African American patients. One set of researchers used the NUDIST computer program for analyzing qualitative data, and the other researchers manually reviewed each line of the focus group transcripts to identify all reported specific behaviors and environment variables. These condensed sets of data were then revised into a pilot Tucker Culturally Sensitive Health Care Inventory for African Americans (i.e., T-CUSCHI-AA) used in the current study.

The T-CUSCHI-AA consists of 154 questionnaire items that range in content from health care provider behaviors (e.g., "Your doctor is sensitive to your needs") to health care environment variables (e.g., "The clinic has African American art") that focus group participants identified as being relevant to the provision of culturally sensitive health care. Based on information provided by focus group respondents in Pedersen (2000), the T-CUSCHI-AA consists of the following subscales:

- Trust in health care provider.
- Comfort with health care provider.
- Perceived sensitivity to and respect for patients' culture by health care providers.
- Comfort with clinic staff (e.g., front desk staff).
- Comfort with the clinic's physical environment.

Sample participants rated each item on a 5-point, Likert-type scale from 1 (strongly agree) to 5 (strongly disagree) as to the degree to which each item was indicative of the type of health care that they had received.

Items on the T-CUSCHI-AA were scored so that high scores reflected greater perceived cultural sensitivity with health care received. Specifically, items rated as "1 -

strongly agree" were scored as 5 points, items rated as "2 - agree" were scored as 4

points, items rated as "3 - not sure/neutral" were scored as 3 points, items rated as "4 -

disagree" were scored as 2 points, and items rated as "5 - strongly disagree" were scored

as 1 point. The T-CUSCHI-AA is scored by adding the scored values for all items to

yield a total score. Missing data on the T-CUSCHI-AA was corrected for by substituting

respondents' mean score on a subscale of the T-CUSCHI-AA for each omitted item on

that subscale. Out of a possible range between 154 and 770, the sample T-CUSCHI-AA

scores in this study ranged from 384 to 738.80. The sample mean was 543.78, with a

standard deviation of 81.72. Higher total scores on the T-CUSCHI-AA are associated

with greater perceived cultural sensitivity in health care received, while lower scores are

associated with lower levels of perceived cultural sensitivity in health care received. The

internal consistency reliability of the T-CUSCHI-AA subscales in this study ranged from

.95 to .97, and its overall (total T-CUSCHI-AA) internal consistency reliability was .98.

Test-retest reliability and validity of the T-CUSCHI-AA has not yet been established.

Permission to use and reprint the T-CUSCHI-AA has been obtained from the author.

Procedure

This study consisted of two phases: (1) participant recruitment, and (2) collection

of data.

Phase I: Recruitment of Participants

Participants in this investigation were selected from a 'master list' of patient

names obtained from a database and provided by the Veterans Administration Network

Knowledge Office in Albany, NY. Four hundred ninety-five (495) patient names were

generated by whether they met criteria for participation. Criteria for patient participation included that participants were adult males (i.e., above age 18 years old), African American, cognitively competent (i.e., able to communicate verbally or in writing), and have been seen in primary care at the Syracuse VA Medical Center on an outpatient basis within the last 24 months. Patients who were identified as meeting criteria according to the VA Network Knowledge Office's records were placed on the 'master list' and deemed eligible for telephone recruitment.

All African American veterans identified on the 'master list' were initially mailed a letter from the Minority Veterans Coordinator at the Syracuse VA Medical Center prior to the initial phone contact by the study's investigator. The letter alerted all eligible veterans to the following:

- The nature and purpose of this research.

- That patients may be contacted by telephone and invited to participate.

- That patient participation is voluntary and that they may decline to participate without it affecting their health care from the Syracuse VA Medical Center.

- That participants will be asked to complete a set of questionnaires about their health care experiences.

- That participants will be paid $15 as compensation for participating.

- That participants' responses will be kept confidential.

- That this research project is endorsed by the Minority Veterans Coordinator.

- That veterans' participation in this research is welcomed.

Out of 495 letters mailed to all potential African American veterans identified on the 'master list,' 54 letters were returned by mail to the investigators for reasons including that the patient had moved with no forwarding information and that the patient

was deceased. Two patients were mistakenly identified as African American when they were Caucasian American. In addition, 78 veterans on the 'master list' did not have telephone numbers on record in order to be contacted and invited by telephone to participate. The remaining 363 veterans were eligible for telephone invitation and for participating in the present study.

Approximately two weeks after the letter from the Minority Veterans Coordinator was mailed, eligible patient participants were randomly selected from the 'master list' and contacted by telephone and invited to participate in the present investigation. Patients were informed of the purpose of the contact and research project, the requirements of them as participants (i.e., completing and returning questionnaires mailed to them or having the questionnaires verbally administered to them at the Syracuse VA Medical Center), the amount of compensation ($15) for participation, and that they would receive the compensation within 3 weeks of the investigators receiving their completed questionnaires. Patients were afforded the opportunity during this phone call to pose any questions or concerns that they had. They were also assured that a decision to decline participation in this study would not affect their health care service at the VA Medical Center.

Of potentially 363 African American veterans who received outpatient primary care services at the Syracuse VA Medical Center over the previous 24 months and whose records included telephone numbers, effort was made to recruit approximately 100 African American veterans for participation. Sixty-four (64) eligible participants were not able to be reached at the telephone number on record (e.g., the phone was disconnected, out of service, patients had moved and changed phone numbers, etc.). An

additional 33 eligible participants did not return telephone messages left by the investigator, and another 18 eligible patients declined to participate citing reasons including lack of time, lack of interest, health reasons, or contempt for the VA based on past problems. Ultimately, 147 eligible patient participants reached by telephone and who expressed an interest in participating were invited to participate in this investigation.

Phase II: Collection of Data

Upon giving their oral consent to participate via the initial telephone contact, patients were offered the option of completing the Health Care Battery (HCB) of questionnaires via mail at their residence or having the HCB verbally administered to them at a the Department of Veterans Affairs Medical Center in Syracuse. Patients to whom questionnaires were mailed were given the option of completing the battery of questionnaires alone or having it read to them by a family member, friend, or acquaintance. All 147 patients who had expressed an interest in participating opted to have the HCB mailed to them. Eight patients subsequently contacted the investigator in order to coordinate an appointment with the investigator at the Syracuse VA Medical Center in order to assist these patients with completion of the HCB and/or discuss patients' concerns about their participation.

The HCB packet mailed to eligible patients included 2 cover letters, 2 copies of a written informed consent form, and the Health Care Battery (HCB) to be completed. The first cover letter was a brief letter of endorsement by the Syracuse VA Minority Veterans Coordinator, Mr. Odie Freeman, encouraging potential recruits to participate in this investigation (Appendix E). The second cover letter was written by this study's

investigator and Dr. Robert Sprafkin, Principal Investigator for this project at the

Syracuse VA Medical Center (Appendix F). This letter briefly described the following:

- Who the investigators were.

- The purpose and nature of the investigation.

- Patient compensation of $15 for participation to be mailed within 3 weeks following completion of the HCB.

- That patient participation in this investigation was voluntary.

- That the anticipated duration for completion of the HCB was approximately 30 minutes.

- That patients' responses would be kept confidential and stored in a locked file cabinet in Dr. Sprafkin's office at the Syracuse VA Medical Center.

The HCB consisted of the following instruments: The Demographic Data

Questionnaire (DDQ), the African American Acculturation Scale - Revised (AAAS-R),

the Patient Satisfaction Questionnaire Short-Form (PSQ-18), the Tucker Culturally

Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA), and the

Marlowe-Crowne Social Desirability Scale–Short Form [M-C (20)]. These instruments

were placed in the packets in random order so as to control for any order effects on the

results.

Participants who chose to complete the HCB at home were instructed to return

their completed HCB and a signed informed consent to the Principal Investigator at the

Syracuse VA Medical Center in a stamped, addressed envelope provided in the HCB

packet. Fifty-five (55) eligible patient participants who had not returned their completed

HCBs within 3 weeks were contacted via telephone by the investigator to determine their

interest in participating and to remind them to return their HCB as soon as possible.

Patient participants who returned their completed HCB and informed consent forms were mailed a check for $15 within 3 weeks as compensation for their participation.

Total patient recruitment and participation took place over a 3 month period. Out of 147 HCB packets mailed out to eligible patients who expressed interest in participating and who agreed by telephone to participate in this investigation, approximately 72% of eligible patients consented to participate and completed the HCB. The final sample for this study consisted of 106 African American male veterans who received outpatient primary care service at the Syracuse VA Medical Center during the previous 24 months.

CHAPTER 4
RESULTS

The descriptive data, hypotheses, and research questions of interest in this study are discussed in this chapter. The results are presented in several parts. First, descriptive data on the major variables of study in this investigation are reported. Second, the results of preliminary correlational analyses that assessed the degree to which patient demographic characteristics and patients' tendency to respond in a socially desirable manner (as scored on the Marlowe-Crowne Social Desirability Scale–Short Form) are related to the dependent variables in the hypotheses and the research questions are reported. Third, I report the results of the correlational analysis to test Hypotheses 1 through 3 in this investigation. Lastly, the multiple regression analysis to test Hypothesis 4 and the statistical analyses to assess the research questions are presented.

Descriptive Statistics for the Major Research Variables

The descriptive statistics on all of the major variables in this study based on the sample for this research are presented in Table 4-1. Specifically, the following are summarized from the sample's data: (a) level of patient satisfaction (PS) with health care received as assessed on the General Satisfaction scale of the Patient Satisfaction Questionnaire Short-Form (PSQ-18), (b) level of acculturation (ACC) as assessed on the African American Acculturation Scale–Revised (AAAS–R), and (c) level of perceived cultural sensitivity (PCS) with health care received as assessed on the Tucker Culturally

Table 4-1

Descriptive Statistics for the Major Research Variables

Variable	$\underline{N}$	Minimum	Maximum	Mean	Std. Dev
PS	106	2.00	5.00	3.41	0.77
ACC	106	88.00	298.63	207.12	43.44
PCS	106	384.00	738.80	543.78	81.72

Note: PS = level of patient satisfaction with health care received; ACC = level of acculturation; and PCS = level of perceived cultural sensitivity in health care received.

Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA). Normative data on the major variables in this investigation is not available.

Preliminary Correlational Analyses

Preliminary correlational analyses were performed in order to determine if there was an association between patient demographic characteristics and scores on the Marlowe-Crowne Social Desirability Scale–Short Form and scores on the major variables of the study: (1) level of patient satisfaction (PS) with health care received, (2) level of acculturation (ACC), and (3) level of perceived cultural sensitivity (PCS) in health care received. First, a Pearson correlational analysis was performed to assess the association of patients' age, number of health-related visits to the VA Medical Center during the last 24 months, and social desirability scores (SDS) on the Marlowe-Crowne Social Desirability Scale–Short Form with the major variables in this investigation. The correlation coefficients for these demographic variables, the Marlowe-Crowne Social Desirability Scale–Short Form scores, and the scores on the major variables of study are presented in Table 4-2. Results showed that social desirability in responding as

Table 4-2

Correlation Coefficients for Social Desirability Scores (SDS), Patient Age (age), Patient
Level of Education (education), Patient Income Level (income), Number of Health-
Related Visits in the Last 24 Months (visits), Patient Ratings of Overall Health
(health), Level of Patient Satisfaction (PS), Level of Acculturation (ACC), and Level
of Perceived Cultural Sensitivity in Health Care Received (PCS)

	SDS	age	education	income	visits	health
PS	0.12	0.20^*	-0.18	-0.22^*	-0.03	0.09
ACC	-0.25^*	-0.14	0.10	0.05	0.09	-0.02
PCS	0.18	0.30^{**}	-0.24^*	-0.18	-0.12	-0.01

Note: $^*p < .05$, $^{**}p < .01$

measured by the Marlowe-Crowne Social Desirability Scale–Short Form was negatively
associated with one of the major variables in the study - patients' level of acculturation
(ACC), $r = -.25$, $p < .05$. The Pearson correlational analysis also revealed that patients'
age was positively and significantly associated with major variables in this study
including of level of perceived cultural sensitivity (PCS) with health care received as
measured on the T-CUSCHI-AA, $r = .30$, $p < .01$, and level of patient satisfaction (PS)
with health care received as measured on the PSQ-18, $r = .20$, $p < .05$. Number of health-
related visits to the VA Medical Center during the previous 24 months was not
significantly associated with participants' scores on the major variables.

A preliminary multiserial correlational analysis was also performed to assess the
degree of association between patient demographic variables including level of
education, level of income, and patients' perceptions of their overall health with the
major variables of this study. The correlation coefficients for this analysis are included in

Table 4-2. Participants' income level was found to be negatively associated with PS, $r =$ -.22, $\underline{p} < .05$, and patients' level of education was negatively associated with PCS, $r =$ -.24, $\underline{p} < .05$. Veteran participants' self-ratings of overall health were not significantly associated with their scores on the major variables of study in this investigation.

In addition to the above Pearson and multiserial correlational analyses, a preliminary point biserial correlational analysis was also performed to assess whether or not veteran participants' requirement to pay or not pay for their most recent primary care health visit influenced their scores on the major variables of study including level of acculturation, level of patient satisfaction, and level of perceived cultural sensitivity with health care. This analysis was performed because veterans vary in their coverage of VA health services, with some required to pay or co-pay for health-related visits, whereas other veterans do not have such expenses. Results of the point biserial correlational analysis revealed that participants' having to pay for their last primary care outpatient visit to the VA Medical Center was negatively associated with PS, $r = -.20$, $\underline{p} < .05$, but requirement to pay was not associated with ACC, $r = .04$, $\underline{p} \leq .68$, or with PCS, $r = -.07$, $\underline{p} \leq .49$. Post hoc t-tests showed that veterans who did not have to pay for their most recent primary health care visit to the VA Medical Center reported greater satisfaction with health care received ($\underline{M} = 3.55$) than veterans who did have to pay for their most recent visit ($\underline{M} = 3.22$), $\underline{t}$ (104) = 2.08, $\underline{p} < .05$. Veteran participants who did not have to pay for their health care services at the VA were not significantly different from patients who had to pay in terms of their level of acculturation, $\underline{t}$ (104) = -0.42, $\underline{p} \leq .68$, or their level of perceived cultural sensitivity with health care received, $\underline{t}$ (104) = 0.70, $\underline{p} \leq .49$.

Based on the preliminary correlational analyses, the analyses used to test this study's hypotheses and research questions controlled for the influence of social desirability (SDS) when investigating level of acculturation (ACC), controlled for the influence of age, income level, and requirement to pay when investigating level of patient satisfaction (PS) with health care received, and controlled for the influence of age and level of education when investigating level of perceived cultural sensitivity (PCS) with health care received.

Analysis of Hypotheses 1, 2, and 3

This study examined the following three hypotheses:

- There will be a significant positive association between African American veteran outpatients' level of satisfaction (PS) with the health care that they report experiencing and their level of acculturation (ACC) such that the greater degree of acculturation, the greater the satisfaction with health care that they report experiencing.

- There will be a significant positive association between African American veteran outpatients' level of acculturation (ACC) and their perceptions of their health care providers and health care environments to be culturally sensitive (PCS) such that the greater the degree that patients' are acculturated, the more they will perceive their health care received to be culturally sensitive.

- There will be a positive association between African American veteran outpatients' level of reported satisfaction (PS) with health care received and their level of perceived cultural sensitivity (PCS) in health care received such that the greater satisfaction with health care reported, the greater the perceived cultural sensitivity in health care received that they will report receiving.

To test Hypotheses 1, 2, and 3, a partial correlation analysis was performed. A partial correlation was used to control for the influence of social desirability as it was found to be significantly correlated with level of acculturation (ACC), to control for the influence of age because it was found to be significantly correlated with level of patient satisfaction (PS) and level of perceived cultural sensitivity (PCS), to control for the

influence of level of education because it was found to be significantly correlated with level of perceived cultural sensitivity (PCS), and to control for the influences of level of income and whether patients were required to pay because these factors were found to be significantly correlated with level of patient satisfaction (PS). Results for Hypothesis 1 indicated that there was no significant relationship between patients' level of acculturation (ACC) and their level of satisfaction (PS) with health care reported, r = .03, $p \leq .78$. Thus, Hypothesis 1 which stated that greater acculturation would be positively associated with higher levels of satisfaction with health care received was not supported.

Results from the partial correlation analysis also revealed that there was no significant correlation between level of acculturation (ACC) and level of perceived cultural sensitivity (PCS) with health care received, r = .08, $p \leq .43$. Thus, Hypothesis 2 which stated that greater acculturation would be positively associated with higher levels of perceived cultural sensitivity with health care received was not supported.

Results from the partial correlation analysis to test Hypothesis 3 that African American veteran outpatients' level of satisfaction (PS) with health care received would be positively associated with their level of perceived cultural sensitivity (PCS) with health care received revealed a significant positive correlation, r = .71, $p < .001$. Specifically, higher scores on the General Satisfaction scale of the Patient Satisfaction Questionnaire Short-Form (PSQ-18) corresponded with higher scores on the Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA). Thus it appears as though African American male veterans who perceived their health care providers to be more culturally sensitive likewise reported that they were more

satisfied with their health care received. The partial correlation coefficients from the

partial correlation analysis to test Hypotheses one, two, and three are presented in Table

4-3.

Table 4-3

Partial Correlation Coefficient Matrix from the Partial Correlation Analysis Performed
 to Assess the Relationships among Level of Acculturation (ACC), Level of Patient
 Satisfaction (PS), and Level of Perceived Cultural Sensitivity with Health Care
 Received (PCS)

	ACC	PS	PCS
ACC	-	0.03	0.08
PS	0.03	-	0.71*
PCS	0.08	0.71*	-

Note: *$p < .001$

Multiple Regression Analysis of Hypothesis 4

Hypothesis four predicted that the relationship between level of perceived

cultural sensitivity in health care received and reported level of satisfaction with health

care received among African American veteran outpatients will be significantly

influenced by African American veteran outpatients' level of acculturation. A forward

stepwise multiple regression analysis was performed to test this hypothesis with patient

satisfaction (PS) with health care received as the criterion variable, and patients' level of

perceived cultural sensitivity (PCS) with health care received, patients' level of

acculturation (ACC), and the interaction of patients' level of perceived cultural

sensitivity (PCS) with health care received and level of acculturation (ACC) as the

predictor variables. Because of their correlation with the major variables in this

investigation, social desirability, patient age, patient level of education, patient level of income, and patient requirement to pay were also included as predictors in this stepwise multiple regression analysis in order to best determine which combination of variables best predicted African American veteran outpatients' level of satisfaction (PS) with health care received.

Results of the forward stepwise multiple regression analysis showed that patients' level of perceived cultural sensitivity (PCS) and whether patients were required to pay for their last primary care outpatient visit significantly predicted level of patient satisfaction, $[\underline{F}(2, 103) = 64.09, \underline{p} < .001, \underline{r}^2 = .55]$. A review of the regression coefficients in this analysis revealed that PCS accounted for the largest amount of variance in patient satisfaction, $[\underline{F}(1, 104) = 118.17, \underline{p} < .001, \underline{r}^2 = .53]$, whereas patients' requirement to pay $[\underline{F}(1, 103) = 5.22, \underline{p} < .05, r^2 = .02]$ was a small but significant contribution to this regression model. Neither level of acculturation (ACC) nor the interaction of ACC and PCS achieved statistical significance to be retained in the stepwise regression model. This finding suggests that among African American veteran outpatients in this research, patients' level of acculturation failed to significantly predict the relationship between patients' level of perceived cultural sensitivity in health care received and their reported level of satisfaction with health care received.

Analyses of Research Questions 1 and 2

Research Question 1 asked whether there were significant differences in African American veteran outpatients' level of perceived cultural sensitivity (PCS) in health care received, level of satisfaction with health care received (PS), and level of acculturation (ACC) in association with patients' age or education level? Two separate analyses were

used to test this question. First, a MANCOVA was used with patients' age and education level as the independent variables, and patient's level of satisfaction (PS) with health care received and level of patients' perceived cultural sensitivity in health care received (PCS) as the dependent variables. Patients' income level and requirement to pay were entered as covariates to control for their influence as they were significantly correlated with PS. Also, a separate ANCOVA was used to test whether there was a significant difference in patients' level of acculturation (ACC) in association with patients' age and education level because ACC had been found not to be correlated with the other dependent variables tested in the MANCOVA analysis. Social desirability (SDS) was entered as a covariate in the ANCOVA analysis to control for its influence as it had been found to be significantly correlated with ACC.

In order for there to be sufficient power in both the MANCOVA and ANCOVA analyses, participants' age and education level were categorized into 3 levels and 2 levels of each factor, respectively. Specifically, age was divided into 3 group levels including those 45 years and younger ($\underline{n} = 29$), those 46 years to 60 years ($\underline{n} = 48$), and those older than 60 years ($\underline{n} = 29$). Since some levels of reported education completed were identified as too small a sample size (e.g., those veterans who only completed elementary school, graduate school, etc.), patients' education level was divided into two groups - those patients who had completed high school or less ($\underline{n} = 41$) and those who had completed some form of education beyond high school ($\underline{n} = 65$).

In the MANCOVA performed to investigate research Question 1 with level of patient satisfaction (PS) with health care received and level of perceived cultural sensitivity (PCS) with health care received as dependent variables, results indicated that

there were no significant main effects for age [$\underline{F}$ (4, 196) = 1.95, $\underline{p} \leq .11$] or education level [$\underline{F}$ (2, 97) = 2.10, $\underline{p} \leq .13$]. Similarly, there was no significant interaction effect for age x education level [$\underline{F}$ (4, 196) = 0.75, $\underline{p} \leq .56$]. However, follow-up univariate ANOVAs on each dependent variable showed that participants' level of PCS did differ as a function of their level of education. Specifically, participants who completed high school or less reported greater perceived cultural sensitivity in health care received ($\underline{M}$ = 571.52, $\underline{SD}$ = 77.22) than those participants who had completed some form of education beyond high school ($\underline{M}$ = 526.29, $\underline{SD}$ = 80.16), [$\underline{F}$ (1, 98) = 3.90, $\underline{p}$ = .05]. There were no statistically significant differences in PCS as a function of participants' age [$\underline{F}$ (2, 98) = 2.60, $\underline{p} \leq .08$]. Likewise, differences in patient satisfaction (PS) as a function of education level [$\underline{F}$ (1, 98) = 0.99, $\underline{p} \leq .33$] or participants' age [$\underline{F}$ (2, 98) = 2.38, $\underline{p} \leq .10$] failed to reach statistical significance.

Consistent with the preliminary Pearson correlational analysis, these findings from testing research Question 1 suggest that less educated African American veteran outpatients perceive their health care providers and health care environment to be more culturally sensitive than more educated patients. However, these results also contradict the results reported in the preliminary Pearson correlational analysis wherein age was significantly associated with PS and PCS. Two issues may account for this discrepancy. First, given the sample size, it is possible that the MANCOVA did not have sufficient power to detect significant differences in PS and PCS as a function of patients' age. Also, it is possible that the categorization of age into 3 levels in the MANCOVA may have altered the association between participants' age and their scores on the dependent measures of PS and PCS.

In the ANCOVA used to test research Question 1 as to whether differences in level of acculturation (ACC) were associated with age and education level, results indicated that there were no significant differences in ACC in association with age [F (2, 99) = 1.22, $p \leq .30$], level of education completed [F (1, 99) = 0.51, $p \leq .48$], or age x education level [F (2, 99) = 0.60, $p \leq .55$].

Research Question 2 asked whether there were significant differences in African American veteran outpatients' level of perceived cultural sensitivity (PCS) in health care received and level of satisfaction with health care received (PS) in association with the gender or ethnicity of their health care providers? Part of the initial intent of this research question was to examine what sorts of differences existed on the dependent variables (i.e, PCS and PS) in association with whether African American veteran outpatients had ethnically concordant relationships with their health care provider (i.e., African American health care provider) or ethnically discordant relationships with their health care providers (i.e., Caucasian American, Hispanic American, etc.). However, after data collection it had become apparent that this type of analysis would be inappropriate given the large proportion of health care providers who were identified as Caucasian, and the finding that only one veteran outpatient identified his primary care provider as African American. Patients' reports of their health care providers' race/ethnicity and gender is presented in Table 4-4. In order to address this research question and whether health care providers' ethnicity or race may influence PS and PCS, health care providers were grouped into whether they were Caucasian (n = 82) or non-Caucasian (n = 18) for the analysis to test research Question 2.

Table 4-4

Patients' Reports of Their Health Care Providers' (HCP) Ethnicity/Race and Gender

Variable	$\underline{N}$	$\%$
HCP Ethnicity/Race:		
Caucasian/White	82	77.4
African American/Black	1	0.9
Hispanic/Latino/Mexican	1	0.9
Asian/Oriental American	7	6.6
Native American	0	0.0
Middle Eastern	6	5.7
East Indian	2	1.9
Other	1	0.9
Do Not Know	6	5.7
HCP Gender:		
Male	69	65.1
Female	37	34.9

A MANCOVA was applied to test research Question 2, with health care providers' (HCP) gender and ethnicity (Caucasian versus non-Caucasian) as independent variables, and PS and PCS as the dependent variables. Participants' age, level of education, income level, and requirement to pay were entered as covariates to control for their influence as these factors had been shown to be associated with one or both of the dependent variables. Results of the MANCOVA showed that there was no significant interaction effect for HCP gender x ethnicity [$\underline{F}$ (2, 91) = 0.96, $\underline{p} \le .39$], nor was there a significant main effect for HCP gender [$\underline{F}$ (2, 91) = 1.68, $\underline{p} \le .20$]. However, a main effect for HCP ethnicity approached statistical significance [$\underline{F}$ (2, 91) = 3.00, $\underline{p} < .06$]. Follow-up one way ANOVAs for PS and PCS revealed that patients reported greater levels of perceived cultural sensitivity (PCS) with health care received on the T-CUSCHI-AA when their HCP was Caucasian ($\underline{M}$ = 553.49, $\underline{SD}$ = 80.93) as opposed to

when their HCP was non-Caucasian ($\underline{M}$ = 503.02, $\underline{SD}$ = 79.13), [$\underline{F}$ (1, 92) = 5.13, $\underline{p}$ < .05]. No statistically significant differences were found in African American veteran outpatients' level of satisfaction (PS) reported in association with whether their HCP was Caucasian ($\underline{M}$ = 3.49, $\underline{SD}$ = 0.76) or non-Caucasian ($\underline{M}$ = 3.14, SD = 0.85), [$\underline{F}$ (1, 92) = 0.84, $\underline{p} \le$ .37].

Lastly, in an attempt to further explore the results of the analysis to test research Question 2, post hoc analyses were performed on the subscales of the T-CUSCHI-AA in order to determine whether African American veteran outpatients with Caucasian HCPs were perceived as more culturally sensitive on the HCP behavior subscales as compared to veterans with non-Caucasian HCPs. Specifically, separate ANCOVAs were performed with HCP ethnicity as the independent variable, and participant age and education level as covariates. The dependent variable in each ANCOVA was participants' scores on the T-CUSCHI-AA subscales of perceived trust (TRUST) in HCP, perceived comfort (COMFORT) with HCP, perceived respect (RESPECT) and sensitivity to the patient's culture by their HCP, comfort with clinic staff, and comfort with clinic environment. Results of the ANCOVAs revealed that African American veteran outpatients with Caucasian HCPs reported higher levels of perceived cultural sensitivity in health care received, relative to those with non-Caucasian HCPs, across the T-CUSCHI-AA dimensions of TRUST [$\underline{F}$ (1, 96) = 5.12, $\underline{p}$ < .05], COMFORT [$\underline{F}$ (1, 96) = 5.42, $\underline{p}$ < .05], and RESPECT [$\underline{F}$ (1, 96) = 8.82, $\underline{p}$ < .01]. As would be expected, African American patients with Caucasian HCPs did not statistically differ from patients with non-Caucasian HCPs in how culturally sensitive they perceived the VA (non-HCP)

clinic staff to be, [F (1, 96) = 1.64, $p \leq .21$], or how culturally sensitive they perceived the VA health care environment to be [F (1, 96) = 1.77, $p \leq .19$].

      Collectively, the results from testing research Question 2 suggest that health care providers' gender was not associated with differences in African American veteran outpatients' level of satisfaction with health care received or level of perceived cultural sensitivity in health care received. However, results did show that African American veteran outpatients with Caucasian health care providers perceived these health care providers to be more culturally sensitive than did African American veteran outpatients with ethnic minority, mostly non-African American, health care providers.

CHAPTER 5
DISCUSSION

African Americans are at risk to experience poorer health status and a shorter life expectancy than Caucasian Americans. It has been widely speculated that cultural differences between African American patients and their health care providers may contribute to this health disparity. However, there has been a paucity of research on the role that culture plays in the health outcomes that African Americans experience.

The purpose of the current investigation was to examine the role that African American veteran outpatients' cultural background and perceptions of how their health care providers attend to their cultural background in the provision of health care are associated with patients' satisfaction with health care received. Specifically, this study examined the relationship among patients' perceived cultural sensitivity in health care received, level of acculturation, and satisfaction with health care received. Whether patients' level of acculturation influenced the relationship between patients' perceived cultural sensitivity with health care received and patients' satisfaction with health care received was also explored. In addition, this study examined whether there were differences in level of perceived cultural sensitivity, level of acculturation, or satisfaction with health care associated with patient characteristics such as age or level of education. Finally, this study assessed whether there were significant differences in African American veteran outpatients' perceptions of how culturally sensitive their health care

providers were and how satisfied they were with health care received in association with the gender or ethnicity of their health care providers.

Summary and Interpretation of Results

In order to assess any influence of demographic characteristics and socially desirable response tendencies on patients' responses on measures of the major variables of study in this investigation (i.e., acculturation, patient satisfaction, and perceived cultural sensitivity), preliminary correlational analyses were performed to examine these influences. Results of a Pearson correlational analysis revealed that social desirability scores (SDS) were negatively correlated with patients' acculturation (ACC) scores. This negative correlation suggests that African American veterans may have reported that they were more acculturated than they actually were. This finding is significant because previous research that has assessed level of acculturation in association with health-related behaviors and outcomes (Hines, Snowden, & Graves, 1998; Landrine & Klonoff, 1996) has failed to control for the effects of a response bias or social desirability among research participants. Accordingly, the current investigation statistically controlled for a response bias associated with level of acculturation by including social desirability as a covariate in all subsequent analyses involving acculturation.

The preliminary Pearson correlational analysis also revealed a positive correlation between patients' age and the variables of patient satisfaction (PS) and perceived cultural sensitivity (PCS) with health care received. Specifically, as participants' age increased, the more participants tended to perceive their health care received as culturally sensitive and to report being satisfied with health care received. Although this finding is consistent with the meta-analytic review on patient satisfaction

reported by Hall and Dornan (1990), these findings are especially important in the context of the current investigation because it suggests that participants' age could systematically bias the correlations being investigated. Accordingly, patients' age was statistically controlled for in subsequent analyses investigating patients' satisfaction (PS) with and perceived cultural sensitivity (PCS) in health care received.

A preliminary multiserial correlational analysis showed a small but significant negative correlation between participants' level of education and their level of perceived cultural sensitivity (PCS) in health care received. This finding suggests that as level of education increased among African American veterans in this study, the likelihood of their perceiving their health care received to be culturally sensitive decreased. This finding is significant because the current investigation is the first of its kind to explore the relationship between African American patients' level of education and the degree to which they perceive their health care providers to be culturally sensitive. In order to control for the influence of patients' level of education on PCS, patients' education level was statistically controlled for in subsequent analyses.

Lastly, the results of preliminary correlational analyses revealed that participant economic factors were associated with the satisfaction with health care that participants reported. Participants' level of income was negatively associated with satisfaction (PS) with health care received. The results showed that greater income levels reported by African American veterans was associated with lower satisfaction scores with health care reported. Similarly, a preliminary point biserial correlational analysis revealed a negative correlation between participants' requirement to pay for health care services and their satisfaction (PS) with health care received. Post hoc t-tests indicated that

African American veterans who had to pay or co-pay for their most recent primary health care visit were significantly less satisfied than those veterans who did not have to pay for their most recent primary health care visit to the VA Medical Center. This finding is significant given that approximately one-third of African American veterans in the current investigation reported having to pay for their most recent health care visit to the Syracuse VA Medical Center. Indeed, veterans who receive care at the VA may have to pay for services unless they have service-connected disabilities, socioeconomic need, or other forms of health insurance that would cover VA expenditures.

These findings are inconsistent with previous research (e.g., Hall and Dornan, 1990) that has reported that patients with higher incomes may be more satisfied with their health care. One explanation for this difference may be that African American veterans with higher incomes are more likely to have to pay for their health services, and hence may be more critical of the care that they receive than those who do not have to pay. In order to control for the influence that these economic factors could have on the relationship between patient satisfaction, perceived cultural sensitivity, and level of acculturation, patients' level of income and requirement to pay for health care were statistically controlled for in subsequent analyses.

Findings in this research do not provide support for Hypothesis 1. Hypothesis one predicted that there would be a significant positive association between participants' level of satisfaction (PS) with health care received and their level of acculturation (ACC). A partial correlational analysis performed to examine Hypothesis 1 revealed no significant relationship between these two variables. This finding suggests that African

American veterans who are more acculturated are not more likely to be satisfied with the health care services that they receive.

Although this study is the first to investigate the relationship between African Americans' level of acculturation and satisfaction with health care received, the current finding that patient satisfaction is not significantly related to patients' level of acculturation is inconsistent with previous research that has examined the relationship between acculturation and health status and health outcomes. Landrine and Klonoff (1996) reported that African Americans (male and female) who were more acculturated were less likely to engage in unhealthy behaviors such as smoking and were less likely to suffer from hypertension relative to less acculturated (more traditional) African Americans.

It is important to note that previous research on acculturation and its association with health has focused on how patients' level of acculturation is associated with their "own" behaviors (e.g., smoking, health care utilization, etc.). However, the current investigation focuses on the association between level of acculturation and one's perceptions of 'others' behaviors (i.e., how satisfied patients are with the quality of care provided by health care providers, etc.) Thus, level of acculturation may be associated with one's own health-related behaviors, but it may not be associated with patients' perceptions of the quality of health care provided by others.

Hypothesis 2 in this study stated that there would be a significant positive association between African American veteran outpatients' level of acculturation and the degree to which they perceive their health care providers and health care environments to be culturally sensitive. Like Hypothesis 1, this association was not found via a partial

correlational analysis. Therefore, there was no support for the prediction that African American patients who are more acculturated perceive their health care received to be more culturally sensitive than less acculturated patients.

Although the current investigation is the first empirical effort to directly evaluate the degree of relationship between patients' perceptions of their health care received and their level of acculturation, the lack of relationship between these two variables is a bit surprising. Specifically, it has been suggested in the literature that less acculturated (more traditional) ethnic minority members may possess health beliefs and participate in health-related practices and traditions that are incongruent with the biomedical model of health espoused by most Western health care institutions (Anderson, 1991; Brookins, 1993; Pachter, 1994). It has been suggested that such cultural differences may be associated with patients perceiving their health care providers as less culturally sensitive and limit the effectiveness of the therapeutic relationship. Indeed, research that has found that less acculturated African American women may be at greater risk for AIDS transmission has suggested that mistrust of health care professionals may be a contributing factor (Hines, Snowden, & Graves, 1998). However, the current investigation failed to find a relationship between African American veteran outpatients' level of acculturation and their perceptions of how culturally sensitive they perceived their health care providers and health care environment to be.

One possible explanation for the lack of association between acculturation and perceived cultural sensitivity is that these two measures, although seemingly related, may tap different constructs. Although acculturation as defined by Landrine and Klonoff (1996) refers to the "extent to which ethnic minorities participate in the cultural

traditions, values, beliefs, and practices of their own culture versus that of the dominant 'White' culture," perceived cultural sensitivity (PCS) in this investigation was operationally defined as the degree to which patients perceive their health care providers and health care environments as facilitating trust, comfort, and respect for one's cultural background. Many of the items of the T-CUSCHI-AA, used to evaluate African American veteran outpatients' PCS, were oriented towards broad issues of quality of care that may not have been specific to African American culture. For instance, items such as "your doctor does not make you wait long," "your doctor is nice," and "your doctor has lots of schooling" may encompass constructs of quality health care that extend beyond sensitivity to and respect for one's specific cultural background. In short, perceived cultural sensitivity in this investigation may have evaluated dimensions of health care provision that extend beyond African American veteran outpatients' cultural background. Further empirical validation and reliability of the T-CUSCHI-AA could offer a clearer understanding of this plausible explanation.

Also, much like the explanation for the lack of a relationship found between acculturation and patient satisfaction in this study, it is possible that acculturation may be more closely associated with one's own behavior than one's perceptions or attitudes about 'others.' Whereas level of acculturation is an index of the degree that one participates in the practices and traditions of one's ethnic culture versus that of the dominant culture, perceived cultural sensitivity involves one's attitudes towards or perceptions of 'others' behaviors and characteristics (i.e., how trusting they are, how comforting they are, etc.). Although these seemingly similar constructs would appear to be related, if not interdependent, the current investigation provides no support for this.

However, empirical replication of these findings as well as empirical evaluation of acculturation and its association to perceived cultural sensitivity among other ethnic minority patient groups is recommended.

Hypothesis 3 in this study stated that African American veteran outpatients' perceptions of the cultural sensitivity (PCS) of their health care providers and health care environments would be positively associated with their satisfaction (PS) with health care received. Results of the partial correlational analysis indeed revealed a significant positive association between PCS and PS. As predicted, African American patients who perceived their health care received as more culturally sensitive were similarly more likely to report greater satisfaction with health care received.

The results of the analysis to test Hypothesis 3 are important because this is the first known investigation to directly find a positive association between PCS and PS among African Americans. This finding is consistent with previous research that has found the quality of patient-physician interactions and patient trust in their health care provider to be positively associated with health outcomes including medication adherence, patient satisfaction, and health status (Safran et al., 1998). Given that patient satisfaction has been empirically found to be associated with health outcomes including more continuous health care, medication adherence, compliance to medical regimens, and better health, these findings suggest that perceived cultural sensitivity in health care received could likewise be associated with such optimal health outcomes.

Unfortunately, because the current investigation and analysis was correlational in nature, a true cause and effect relationship between PCS and PS cannot be determined. However, if it is theoretically assumed that patients' perceptions of their health care

providers' cultural sensitivity subsequently leads to their satisfaction with health care received, then the current findings also provide evidence for the validity of the T-CUSCHI-AA used in this investigation. The fact that African American veteran outpatients' scores of perceived cultural sensitivity with health care received on the T-CUSCHI-AA were modestly and positively associated with patient satisfaction scores lend to the validity of the T-CUSCHI-AA as a measure of quality of health care. Future research that explores the convergent and discriminative validity of the T-CUSCHI-AA as well as the causal direction of the relationship between perceived cultural sensitivity with health care received and patient satisfaction is deserving.

Hypothesis 4 in this investigation stated that the relationship between patients' level of perceived cultural sensitivity (PCS) in health care received and reported level of satisfaction (PS) with health care received would be significantly influenced by their level of acculturation (ACC). Results of a stepwise multiple regression analysis revealed that neither ACC nor an interaction between ACC and PCS significantly predicted the variance associated with patient satisfaction. Rather, the multiple regression analysis yielded that PCS in health care received, independent of level of acculturation, accounted for approximately 53% of the total variance in patients' satisfaction (PS) scores. Whether or not African American veteran outpatients were required to pay for their health care visit was also found to be a small, but statistically significant, predictor of patients' satisfaction scores (i.e., this factor contributed independently to about 2% of the total variance associated with patient satisfaction scores). These findings provide little evidence to support that patients' level of acculturation is an influence in their

perceptions of how culturally sensitive they perceive their health care received to be or their satisfaction with health care received.

Nevertheless, these findings are consistent with previous research that has reported that patients' perceptions of the interpersonal and communicative manner in which their health care is provided is the aspect of care that accounts for the greatest amount of variance in patient satisfaction (Aharony & Strasser, 1993; Hall et al., 1988; Stewart et al., 2000). The current investigation strongly indicates that African American veteran outpatients' perceptions of their health care providers' ability to facilitate trust, comfort, and respect and sensitivity to one's culture are indeed important parameters in how satisfied such patients are with their health care experience. Given the close association between patient satisfaction and other indices of patient outcomes and health status, the results of the current investigation provide strong evidence that health care providers and health care environments that are sensitive to the needs and culture of their patients will be well served in promoting the health of their patients. Future research on the validation of the T-CUSCHI-AA and its subscales should be able to shed clearer light on the dimensions of cultural sensitivity that can facilitate better health outcomes.

The results of the multiple regression analysis to test Hypothesis 4 challenge the role that acculturation may play in African American veterans' perceptions of the quality of care that they receive at the VA Medical Center. Although African American veterans in this sample exhibited a range of scores on the African American Acculturation Scale–Revised (AAAS–R) that would be indicative of varying levels of acculturation, it seems that these veterans were not inclined to attend to this aspect of themselves when basing their judgments of perceived cultural sensitivity in health care received or

satisfaction with health care received. This suggests that African American veteran outpatients' may base their judgments of the quality of health care that they receive on values, beliefs, or experiences not adequately tapped by their cultural beliefs and practices endorsed on the AAAS–R.

It is also worth noting that the lack of a relationship between acculturation and the measures of perceived cultural sensitivity and patient satisfaction with health care received may have been limited by the nature of the instrument used. The African American Acculturation Scale–Revised (AAAS–R) by Klonoff and Landrine (2000) and its earlier versions (e.g., Landrine & Klonoff, 1994; Landrine & Klonoff, 1995) are deserving of recognition in their focus on identifying cultural differences among African Americans. Historically, psychology and the health sciences have ignored cultural aspects of African Americans by instead attending to their racial (i.e., physical) characteristics and differences. However, an inherent limitation of the AAAS–R is that it measures acculturation in a unidimensional, linear fashion. Specifically, those who score high on the AAAS–R are indicative of being less acculturated to the dominant "White" culture and those who score lower on the AAAS–R are regarded as being more acculturated. The AAAS–R does not adequately evaluate African Americans' level of biculturalism or multiculturalism.

Research Question 1 investigated differences in African American veteran outpatients' level of perceived cultural sensitivity (PCS) in health care received, level of acculturation (ACC), and level of satisfaction (PS) with health care received in association with patients' age and education level. The results of the MANCOVA used to test this research question showed that participants who reported having completed no

more than a high school education perceived their health care received to be more culturally sensitive than participants who had received formal education beyond high school. Such findings are not consistent with previous research that has reported that physicians provide more time, more information, and have better communication with persons of higher education (Hall et al., 1988, Levy, 1985, Stewart et al., 1999).

Several issues may account for these differences. First, the focus of previous research was specifically on communication patterns between physicians and patients, whereas the current study's focus on cultural sensitivity encompassed patients' perceptions of qualities of their health care providers and health care environment that extended beyond mere doctor-patient communication patterns. Likewise, much of the previous research on communication patterns involved Caucasian patients and non-veterans. As the first investigation to directly evaluate African American veteran outpatients' perceived cultural sensitivity with health care received, this study's results indicate that more highly educated African American veterans perceive their health care providers and health care environment to be less culturally sensitive. These findings suggest the possibility that more highly educated African American veterans may be more conscientious of the manner in which they are treated, or may judge the cultural sensitivity in their health care received with greater scrutiny.

In addition, the results of the MANCOVA used to test research Question 1 revealed that neither age nor education level was associated with differences in PS, and age was not associated with PCS. It is important to note that these findings somewhat contradict the results of the preliminary Pearson correlational analysis reported earlier wherein participants' age was found to be positively associated with both PCS and PS.

A couple of issues regarding the discrepancy in results between the MANCOVA used to test research Question 1 and the preliminary Pearson correlational analysis merit discussion. First, the MANCOVA used to test research Question 1 may not have had sufficient statistical power to detect differences in age between the groups of comparison. Indeed, the preliminary correlational analyses showed that the associations between age and PS and PCS were small. Moreover, unlike the preliminary correlational analysis, participants' age was categorized into 3 levels for the purpose of ensuring appropriate group comparisons and power within the MANCOVA. However, it is plausible that the manner in which participants were categorized by age may not have accurately represented the association between veteran participants' age and PCS and PS. Future research that incorporates a larger sample size could enhance the statistical power of the multivariate analysis and permit more variation in the categorization of participants by age so as to better determine whether any true effects in PCS and PS as a function of participants' age indeed exist.

Given the potential statistical limitations of the MANCOVA used to test research Question 1, it is important to note that the results from the preliminary Pearson correlational analysis regarding patients' age and PS are consistent with previous literature. The current results are consistent with the results reported by Young et al. (2000) wherein PS was found to be significantly associated with veterans being older. However, the results from this study's preliminary correlational analysis that greater PCS was associated with patients' being older is somewhat inconsistent with previously reported research. Previous research has reported that older patients may have less sociocultural exchange and receive more biomedical feedback from their physicians than

younger patients (Roter et al., 1997). Although such previous research is seemingly inconsistent with the current results, it is again important to note that previous research methodologically focused more on communication patterns among primarily Caucasian non-veteran health care consumers. Therefore comparisons between the current results on PCS and those on patient-physician communication patterns may not be appropriate.

The results of the ANCOVA used to test research Question 1 showed that there were no differences in African American veteran outpatients' level of acculturation in association with age and education level. These results are consistent with research reported by Klonoff and Landrine (2000) and Landrine and Klonoff (1994, 1995) in their efforts to validate the African American Acculturation Scale (AAAS). Specifically, these studies reported that acculturation as measured on the total score of the AAAS and AAAS–R was not significantly associated with education, age, income, or city of origin. Given that the purpose of the AAAS–R is to measure acculturation - the extent to which persons are immersed in the dominant culture versus their own culture of origin, acculturation should not be associated with demographic or status variables.

Research Question 2 asked whether there were significant differences in African American veteran outpatients' level of perceived cultural sensitivity (PCS) in health care received and satisfaction (PS) with health care received in association with the gender or ethnicity of their health care providers. Results of the MANCOVA and subsequent univariate analyses used to test this research question revealed no differences in PS in association with gender or ethnicity of health care providers. Also, results did not show significant differences in African American veteran outpatients' PCS in association with their health care providers' gender, but results did show that patients with Caucasian

health care providers perceived their health care providers to be more culturally sensitive than patients with non-Caucasian health care providers. Post hoc ANCOVAs indicated that these differences were statistically significant on the health care provider (HCP) subscales of the Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA) including (a) trust in HCP, (b) comfort with HCP, and (c) perceived respect and sensitivity to one's culture by HCP. No significant differences were found on health care environment subscales of the T-CUSCHI-AA evaluating participants' comfort with clinic staff or comfort with the health care environment as a function of health care providers' ethnicity.

Unfortunately, it is important to note that of the group of participants in this investigation who identified their health care provider as non-Caucasian, only one participant identified his health care provider as African American. Most of the non-Caucasian health care providers were of Asian, Middle-Eastern, or Latino ethnicity. This issue poses a limitation to the interpretability of the current results in terms of how patient-physician ethnic concordance relates to African American veteran outpatients' perceived cultural sensitivity with health care received.

The results from testing research Question 2 are consistent with past research that has found physician's gender to have no effect on patients' report of satisfaction with health care received (Gross et al., 1998; Murphy-Cullen & Larsen, 1984). Although previous research has found that patient-physician concordance in ethnicity either facilitates patient-physician communication and satisfaction with health care or has no effect at all (Cooper-Patrick et al., 1999; Gross et al., 1998; Murphy-Cullen & Larsen, 1984; Perez-Stable et al., 1997; Stewart et al., 1999), the fact that there was only one

ethnically concordant patient-physician relationship in this study limits its comparison to previous research.

However, the results of testing research Question 2 do suggest that ethnic minority, and primarily non-African American, health care providers are perceived as less culturally sensitive in providing health care to African American veteran outpatients. It would be erroneous to assume that just because such health care providers are members of ethnic minority groups that they would provide more culturally sensitive health care to African American veteran outpatients - patients who are ethnically dissimilar from themselves. In fact, the current results suggest that such non-African American ethnic minority health care providers may be less culturally sensitive to the needs and culture of African American veterans, or at least are perceived to be less culturally sensitive than Caucasian health care providers. For instance, it is possible that African American veterans may perceive many of these non-Caucasian health care providers who are ethnically different from themselves to be even more culturally dissimilar (e.g., because of language deficiencies, etc.) and less culturally sensitive than Caucasian health care providers. Unfortunately, the sample of health care providers available at the Syracuse VA Medical Center is indicative of the under-representation of African American health care providers practicing at many health care institutions nationwide. Future research that involves multiple health care settings and that can incorporate a larger sample of African American health care providers would be well served for better understanding how ethnically concordant and ethnically discordant patient-health care provider relationships may contribute to patients' perceived cultural sensitivity in health care received.

Limitations of Study

There are several limitations of this study that warrant mention. First, a major limitation in the present study was the small sample size and potential lack of representativeness of the sample. The current investigation included 106 African American veterans who had received outpatient care at the Syracuse VA Medical Center during the previous two years. This sample size may have limited the reliability of the findings and restricted the power associated with the statistical analyses performed. Because of the limited sample size, the MANCOVA used to test research Question 1 required grouping of some of the levels of the independent variables being investigated, thereby limiting a more sensitive understanding of these variables. For instance, participants identified themselves as having completed varying levels of education, but participants had to be categorized into one of two levels (i.e., those that completed highschool versus those that did not) in order to ensure a sufficient proportion of participants in the comparison groups of that multivariate analysis. A larger sample could have permitted a more complex analysis that took into account other levels of education (e.g., completed college, completed only elementary school, etc.), patient age, and their association with the major variables measured in this investigation.

Related to the problem with sample size, the current study was also limited by the number of African American health care providers available at the Syracuse VA Medical Center. Only one participant in this study identified that he had an African American health care provider, thus making it impossible to evaluate how ethnically concordant patient-physician relationships were associated with the major variables of this study. Likewise, categorizing health care providers into Caucasian and non-

Caucasian for the purpose of attempting to address research Question 2 limited the interpretability of those results. That is, the grouping of all non-Caucasian health care providers limited the ability to draw distinctions between and conclusions about ethnically different patient-physician relationships. Given the national under-representation of African American health care providers and the abolishment of affirmative action programs by numerous state legislatures, the challenge to conduct research with an appropriate sample size of African American health care providers is likely to be ongoing.

The limit in sample size also brings up the larger issues of how to successfully recruit and obtain a representative sample of ethnic minority persons such as African Americans. Although nearly 500 African American veterans were identified as meeting criteria for the current investigation, the author experienced difficulty in trying to contact many of these potential participants. Issues such as patients' moving, being given inadequate or inaccurate forwarding addresses, and patients not having a telephone to be reached at precluded numerous patients from possible participation in this investigation. Such recruitment difficulties are not uncommon among hard to reach populations such as socioeconomically disadvantaged ethnic minority members (Faugier & Sargeant, 1997).

It is also important to note that participants were offered a monetary compensation ($15) for their participation in this investigation. While $15 may have been a strong incentive for some African American veteran patients to participate, others may have been inspired to participate because of their acknowledgment of the significance such research could have for the provision of quality health care for African

American veterans. Given that the majority of veteran participants in this study reported low annual income levels, it is possible that offering such a financial incentive may have skewed the representativeness of this study's sample by attracting and recruiting those who are more economically disadvantaged. Ironically, it is economically disadvantaged ethnic minority members who are often the most underrepresented in health care research.

Another possible limitation of the present study is its limited generalizability. The sample in this investigation consisted of male African Americans who had served in the military, who were predominantly of lower socioeconomic status, and who received health care at a VA Medical Center (VAMC). Caution should be exercised when attempting to generalize these findings to other groups of patients including those of different gender, geographic location, socioeconomic status, cultural background, and patient populations (e.g., non-veterans, inpatients, etc.).

Another important and potential limitation of the current investigation was that only self-report instruments were used. Given that participants were asked to respond to their perceptions of the cultural sensitivity and satisfaction with their most recent outpatient primary health care visit to the VAMC, a few issues may have interfered with the reliability of their reports. First, patients' most recent primary care visit could have occurred anytime within the previous two years. It is possible that participants who recently visited the outpatient primary care service at the VAMC may have been more reliable in their judgements and responses regarding their health care experience than those who had not had a recent outpatient primary health care visit. Likewise, given that veterans can receive health care in many service areas of the VAMC (e.g., the pharmacy,

psychiatry, inpatient services, opthalmology, etc.), it is possible that African American veterans' judgments for the care and service that they received in outpatient primary care could have been tainted by their experiences in these other service areas. Although these are in fact legitimate issues that could limit the reliability of the current findings, it is important to note that patients' perceptions of their health care received, regardless of its reliability, may be as important as what actually occurred during their last visit. If patients perceived that their last health visit was dissatisfying and that they were treated in a culturally insensitive manner, it is likely that such perceptions (rather than what may have actually transpired) will affect their likelihood to comply with treatment recommendations and appropriately use such services in the future.

Another potential limitation of this study was that participants' in this study may have under or over-reported their judgments about themselves and their experiences in a socially desirable manner. The use of self-report inventories in psychological research has historically been plagued with the potential for participants to respond in a manner indicative of defensiveness or need for approval (McCrae & Costa, 1983). The current study appears to be no exception as results showed a significant correlation between social desirability and participants' self-reported level of acculturation. In an effort to address this potential limitation, social desirability was statistically controlled for in the present study.

A final issue that may have limited the current study was the use of the Tucker Culturally Sensitive Health Care Inventory for African Americans (T-CUSCHI-AA) as constructed by Tucker et al. (2001). The current investigation used a pilot version of this instrument that included no formal test-retest data or validity data on the instrument. The

items on the instrument were derived from focus group data and feedback obtained by Pedersen (2000). Moreover, the focus group respondents from Pedersen (2000) were African Americans who had received primary care through community health clinics in North Florida. The feedback provided by these focus group participants and the subsequent items generated from them may not have generalized to African American veterans in this investigation. Indeed, a few veterans commented that some of the items contained on the T-CUSCHI-AA (e.g., "The clinic has a playpen for children") were largely irrelevant for veteran patient populations.

Although some of the results in this study lend support to the reliability (e.g., the internal consistency of the subscale items was high) and validity of the T-CUSCHI-AA (e.g., the association between PS and PCS, differences in PCS as a function of health care provider ethnicity were only significant on the health care provider subscales of the T-CUSCHI-AA and not on the health care environment subscales), formal evaluation of its test-retest reliability and validity is needed. Without test-retest data and research on the validity of the T-CUSCHI-AA, the true meaning of this instrument and its subscales cannot be ascertained. Accordingly, the current results of using this instrument, although a promising first-step in the evaluation of cultural sensitivity with health care received, should be viewed with caution.

Implications for Future Research

The results of the current investigation strongly suggest that patients' perceptions of cultural sensitivity in their health care received are significantly associated with and may in fact predict their subsequent satisfaction with health care received. In particular, African American veteran outpatients' perceptions of their health care providers'

behaviors and variables associated with the health care environment at the Syracuse VA Medical Center significantly predicted how satisfied these participants were with their health visit. Preliminary data on the development of the T-CUSCHI-AA (Pedersen 2000; Tucker et al., 2001) in conjunction with the current results suggest that dimensions such as trust in health care providers (HCPs), comfort with HCPs, comfort with clinic staff, comfort with the VA health care setting, and perceptions of their HCP's respect and sensitivity to one's culture may indeed contribute to the satisfaction with health care that African American veterans report. However, further research on the reliability and validity of the T-CUSCHI-AA, including factor analysis of its items, could lead to a more accurate operational definition of cultural sensitivity and its parameters that contribute to important health outcomes including patient satisfaction.

In addition, replication of the current investigation with a larger sample and with other patient populations seems indicated. Using a larger sample of African American veterans and non-veterans from multiple health care settings could significantly improve the external validity of these findings, and increase the number and ethnic diversity of health care providers in such research. Such improvements in sample size via numerous health care settings could help ensure that an adequate sample of African American health care providers will be obtained. Accordingly, research among a larger sample of African American patients and health care providers could lead to an improved understanding of the role that patient-physician ethnic concordance or discordance can play in patients' perceptions of cultural sensitivity and satisfaction with health care received.

The results of the current investigation using the African American Acculturation Scale - Revised (AAAS–R) suggest that African American veteran outpatients' level of acculturation does not influence their judgments about the quality of health care that they receive. Given the inherent limitation of the AAAS–R to measure African Americans' level of acculturation as a bicultural or multicultural construct, it is recommended that future research be given to the means of evaluating biculturalism and multiculturalism among African Americans before dismissing the construct of acculturation as an influence in patients' health care judgments.

Lastly, future research on variables that may be associated with patients' perceived cultural sensitivity in health care received is warranted. Although the current investigation did not find any significant association between participants' degree of immersion in the dominant culture versus their own culture of origin (i.e., acculturation) and the level of perceived cultural sensitivity (PCS) and satisfaction (PS) with health care received, future research that attends to alternative patient characteristics that may influence the association between PCS and PS is needed. Likewise, although patient satisfaction has been robustly found to be associated with patients' health status and other health outcomes (e.g., adherence, continuity of care, etc.), future research that examines whether perceived cultural sensitivity is associated with behavioral outcomes such as compliance and health status are recommended. Such research could be instrumental in targeting those aspects of providing culturally sensitive health care that is most directly relevant to the promotion of better health among African American health care consumers.

Implications for Psychologists

Despite the limitations that existed in this study, the current investigation and its findings have implications for psychologists. First, psychologists can play an important role in further investigating the association between perceived cultural sensitivity and satisfaction with health care received. This investigation found that perceived cultural sensitivity accounted for approximately 53% of the variance associated with the satisfaction with health care that patients reported. This finding suggests that providing culturally sensitive health care may be an important factor in patients' satisfaction with their health care. Given that perceived cultural sensitivity as defined in this investigation consists of a range of health care provider behaviors and health care environmental influences that facilitate patients' perceptions of trust, comfort, and/or sensitivity to one's cultural background, it is obvious that such behaviors and influences are appropriately within the scope of what psychologists are trained to evaluate. Indeed, psychologists can play a lead role in investigating the parameters associated with the provision of culturally sensitive health care and how its provision is associated with patients' health outcomes and health status. Such research could be instrumental in eliminating the health disparities among all ethnic groups.

In addition, psychologists can play an instrumental role in training health care providers and staff members in ways to improve the cultural sensitivity and quality of health care that they provide to African American patients. Indeed, many of the items associated with perceived cultural sensitivity as measured in this investigation entail interpersonal processes such as health care providers being honest and direct with patients, listening to patients, treating all patients equally, consulting with other

professionals regarding the patient's condition, not looking down on the patient, and exhibiting an understanding of African American culture and illnesses common among African Americans. Behaviors and skills such as these are but a few of the many associated with the provision of culturally sensitive health care for African Americans. Unfortunately, many health care providers are unaware or perhaps underestimate the importance of such skills and behaviors during their encounters with African American patients - behaviors and skills that they are not directly trained to perform. Indeed, such interpersonal skills are often underemphasized in medical training programs (Greenlick, 1995). In contrast, psychologists are typically trained to be competent in interpersonal relationships and to be sensitive to cultural issues and differences in the patient-therapist relationship. Such training and expertise make psychologists well suited to serve as consultants or educators to health care providers and medical students. Accordingly, psychologists can serve a most important function in training health care professionals in the skills and cultural issues associated with African Americans and that can promote optimal health care experiences in such patients.

<u>Implications for Health Care Providers</u>

The current results substantiate the training of health care providers in providing culturally sensitive health care. Specifically, the results suggest that health care providers' ability to facilitate African American patients' trust and comfort, and to understand, respect, and be sensitive to the cultural background of their African American patients may significantly enhance the health care experience of such patients. Indeed, being attuned to and skilled in the cultural issues and behaviors that promote perceived cultural sensitivity in African American patients may increase patients'

satisfaction with their health care encounters. In turn, being more satisfied may increase the likelihood that such patients will adhere to their prescribed regimens, pursue continuity in health care, and improve their health status and quality of life. Ultimately, the provision of culturally sensitive health care could improve the effectiveness of health care delivery, reduce unnecessary health care costs, improve patients' satisfaction and health status, and enhance health care providers' and health care institutions' profits by retaining African American health care consumers that they can more effectively care for.

Conclusion

The current investigation examined African American veteran outpatients' perceived cultural sensitivity in health care received, patient satisfaction with health care received, acculturation, and patients' and health care providers' sociodemographic variables associated with these cultural and health-related variables. Results showed that African American veteran outpatients' perceptions of the cultural sensitivity of their health care providers and the VA health care environment was positively associated with their satisfaction with health care received. Indeed, patients' perceived cultural sensitivity in health care received accounted for approximately 53% of the variance associated with patient satisfaction. Interestingly, African American patients' level of acculturation was not associated with either their level of perceived cultural sensitivity in health care received, nor their level of satisfaction with health care received.

African American veterans with ethnic minority, and primarily non-African American, health care providers perceived their health care received to be less culturally sensitive than veterans with Caucasian health care providers. Also, greater perceived

cultural sensitivity in health care received was associated with veterans being older and less educated, and higher satisfaction with health care received was associated with veterans being older and having lower income. Indeed, economic factors including whether African American veterans' had to pay for their most recent health care visit accounted for only 2% of the variance associated with patient satisfaction. These findings suggest that African American veterans' economic situation may play only a small role, relative to how culturally sensitive they perceive their health care encounter to be, in determining how satisfied they are with the health care that they receive.

Future research on the reliability and validity of the T-CUSCHI-AA (used to evaluate patients' perceived cultural sensitivity in health care received in this study), the association between perceived cultural sensitivity in health care received and health-related behaviors (e.g., adherence to medical regimens) and health outcomes, and the extension of such research to other cultural and patient populations is strongly recommended. The current findings are a first-step in empirically demonstrating the significance of providing culturally sensitive health care in promoting patient satisfaction among culturally diverse patients. Psychologists can use these findings and the results of future similar research as a foundation for educating health care providers about empirically-based strategies for treating African American patient populations. Such training could not only improve health care providers' knowledge of cultural issues and skills in treating African Americans, but could lead to improved health outcomes and health status for the African American patients that they serve.

PATIENT DEMOGRAPHIC DATA QUESTIONNAIRE

Instructions: Please provide the requested information by filling in the blank or circling
the appropriate answer where provided.

Your Age: ____

Your gender: (circle one)
1. Male
2. Female

Your Race/Ethnicity: (circle one)
1. African American or Black American
2. Caucasian American or White American
3. Hispanic American or Latino/Chicano/Mexican American
4. Native American or American Indian
5. Biracial/Multiracial/Other (please specify _____)

Relationship Status: (circle one)
1. Single, living without a partner
2. Single, living with a partner
3. Married, living with a partner
4. Married, living without a partner
5. Divorced or separated
6. Widow/Widower

Employment Status: (circle one)
1. Full Time
2. Part Time
3. Not employed

Highest level of education that you have completed: (circle one)
1. Elementary School
2. Middle/Junior High School
3. High School
4. Some College/Technical School
5. College
6. Professional/Graduate School

Annual household income level: (circle one)
1. Below $10,000
2. $10,001-$20,000
3. $20,001-$30,000
4. $30,001-$40,000
5. Above $40,001

Religious Preference: (circle one)
1. Catholic
2. Baptist
3. Presbyterian
4. Methodist
5. Muslim
6. Islamic
7. Buddhist
8. Jewish
9. No preference
10. Other (Please specify: _____)

How would you rate your overall health? (circle one)
1. Very Poor
2. Poor
3. Fair
4. Good
5. Excellent

Number of health-related visits to the VA Medical Center in the past 24 months: _____

What is the race or ethnicity of your primary doctor or health care provider at the VA Medical Center that you attend: (circle one)
1. Caucasian American or White American
2. African American or Black American
3. Hispanic or Latino/Chicano/Mexican American
4. Asian American or Oriental American
5. Native American or American Indian
6. Middle Eastern
7. East Indian
8. Other (please specify _____)
9. Do not know

What is the gender of your primary doctor or health care provider at the VA Medical Center that you attend: (circle one)
1. Male
2. Female

APPENDIX B
AFRICAN AMERICAN ACCULTURATION SCALE–REVISED

Instructions: Below are some beliefs and attitudes about religion, families, racism, Black people, White people and health. Please tell us how much you personally agree or disagree with the beliefs and attitudes listed below by circling ONE number for each statement. There is no right or wrong answers, we simply want to know your views and your beliefs.

I Totally Disagree/ Not True at All			I Sort of Agree/ Sort of True		I Strongly Agree/ Absolutely True	
1	2	3	4	5	6	7

1. I believe in the Holy Ghost.
    1   2   3   4   5   6   7
2. I like gospel music.
    1   2   3   4   5   6   7
3. I believe in heaven and hell.
    1   2   3   4   5   6   7
4. The Church is the heart of the Black community.
    1   2   3   4   5   6   7
5. I have seen people "get the spirit" or speak in tongues.
    1   2   3   4   5   6   7
6. I am currently a member of a Black church.
    1   2   3   4   5   6   7
7. When I was young, I was a member of a Black church.
    1   2   3   4   5   6   7
8. Prayer can cure disease.
    1   2   3   4   5   6   7
9. What goes around, comes around.
    1   2   3   4   5   6   7
10. I used to sing in the church choir.
    1   2   3   4   5   6   7
11. Most of the music I listen to is by Black artists.
    1   2   3   4   5   6   7
12. I like Black music more than White music.
    1   2   3   4   5   6   7
13. I listen to Black radio stations.
    1   2   3   4   5   6   7
14. I try to watch all the Black shows on TV.
    1   2   3   4   5   6   7

15. The person I admire the most is Black.

    1   2   3   4   5   6   7

16. I feel more comfortable around Blacks than around Whites.

    1   2   3   4   5   6   7

17. When I pass a Black person (a stranger) on the street, I always say hello or nod at them.

    1   2   3   4   5   6   7

18. Most of my friends are Black.

    1   2   3   4   5   6   7

19. I read (or used to read) *Essence* or *Ebony* magazine.

    1   2   3   4   5   6   7

20. I don't trust most White people.

    1   2   3   4   5   6   7

21. IQ tests were set up purposefully to discriminate against Black people.

    1   2   3   4   5   6   7

22. Most Whites are afraid of Blacks

    1   2   3   4   5   6   7

23. Deep in their hearts, most White people are racists.

    1   2   3   4   5   6   7

24. Whites don't understand Blacks.

    1   2   3   4   5   6   7

25. Most tests (like the SATs and tests to get a job) are set up to make sure Blacks don't get high scores on them.

    1   2   3   4   5   6   7

26. Some members of my family hate or distrust White people.

    1   2   3   4   5   6   7

27. When I was young, I shared a bed at night with my sister, brother, or some other relative.

    1   2   3   4   5   6   7

28. When I was young, my parent(s) sent me to stay with a relative (aunt, uncle, grandmother) for a few days or weeks, and then I went back home again.

    1   2   3   4   5   6   7

29. When I was young, my cousin, aunt, grandmother, or other relative lived with me and my family for awhile.

    1   2   3   4   5   6   7

30. When I was young, I took a bath with my sister, brother, or some other relative.

    1   2   3   4   5   6   7

31. Some people in my family use Epson salts.

    1   2   3   4   5   6   7

32. Illnesses can be classified as natural types and unnatural types.

    1   2   3   4   5   6   7

33. Some old Black women/ladies know how to cure diseases.

    1   2   3   4   5   6   7

34. Some older Black women know a lot about pregnancy and childbirth.

    1   2   3   4   5   6   7

35. I was taught that you shouldn't take a bath and then go outside.
    1   2   3   4   5   6   7

36. I avoid splitting a pole.
    1   2   3   4   5   6   7

37. When the palm of your hand itches, you'll receive some money.
    1   2   3   4   5   6   7

38. There's some truth to many old superstitions.
    1   2   3   4   5   6   7

39. I eat Black-eyed peas on New Year's Eve.
    1   2   3   4   5   6   7

40. I grew up in a mostly Black neighborhood.
    1   2   3   4   5   6   7

41. I went to (or go to) a mostly Black high school.
    1   2   3   4   5   6   7

42. I went to a mostly Black elementary school.
    1   2   3   4   5   6   7

43. I currently live in a mostly Black neighborhood.
    1   2   3   4   5   6   7

44. It's better to try to move your whole family ahead in this world than it is to be out for only yourself.
    1   2   3   4   5   6   7

45. Old people are wise.
    1   2   3   4   5   6   7

46. I often lend money or give other types of support to members of my family.
    1   2   3   4   5   6   7

47. A child should not be allowed to call a grown woman by her first name, "Alice." The child should be taught to call her "Miss Alice."
    1   2   3   4   5   6   7

PATIENT SATISFACTION QUESTIONNAIRE SHORT-FORM

These next questions are about how you feel about the medical care you receive.

<u>Instructions</u>: On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving right now or have recently received at the VA Medical Center. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good or bad, about the medical care you have received.

Using the scale below, indicate how strongly do you AGREE or DISAGREE with each of the following statements? Circle only ONE number on each line.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1	2	3	4	5

1. Doctors are good about explaining the reason for medical tests.
   <div align="center">1   2   3   4   5</div>
2. I think my doctor's office has everything needed to provide complete medical care.
   <div align="center">1   2   3   4   5</div>
3. The medical care I have been receiving is just about perfect.
   <div align="center">1   2   3   4   5</div>
4. Sometimes doctors make me wonder if their diagnosis is correct.
   <div align="center">1   2   3   4   5</div>
5. I feel confident that I can get the medical care I need without being set back financially.
   <div align="center">1   2   3   4   5</div>
6. When I go for medical care, they are careful to check everything when treating and examining me.
   <div align="center">1   2   3   4   5</div>
7. I have to pay for more of my medical care than I can afford.
   <div align="center">1   2   3   4   5</div>
8. I have easy access to the medical specialists I need.
   <div align="center">1   2   3   4   5</div>
9. Where I get my medical care, people have to wait too long for emergency treatment.
   <div align="center">1   2   3   4   5</div>
10. Doctors act too businesslike and impersonal toward me.
    <div align="center">1   2   3   4   5</div>

11. My doctors treat me in a very friendly and courteous manner.

              1   2   3   4   5

12. Those who provide my medical care sometimes hurry too much when they treat me.

              1   2   3   4   5

13. Doctors sometimes ignore what I tell them.

              1   2   3   4   5

14. I have some doubts about the ability of the doctors who treat me.

              1   2   3   4   5

15. Doctors usually spend plenty of time with me.

              1   2   3   4   5

16. I find it hard to get an appointment for medical care right away.

              1   2   3   4   5

17. I am dissatisfied with some things about the medical care I receive.

              1   2   3   4   5

18. I am able to get medical care whenever I need it.

              1   2   3   4   5

APPENDIX D
TUCKER CULTURALLY SENSITIVE HEALTH CARE INVENTORY FOR
AFRICAN AMERICANS

Directions: The following are statements that people say about their medical care. Please read each statement carefully, keeping in mind the medical care you are receiving at the VA Medical Center from your general doctor or primary care provider. (If you have not received care recently from your general doctor, think about your last outpatient visit to your general doctor at the VA Medical Center). Please circle the ONE number below each statement that best indicates how you feel about that statement.

Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
1	2	3	4	5

1. Your doctor is honest and direct with you.

| 1 | 2 | 3 | 4 | 5 |

2. Your doctor has a lot of schooling.

| 1 | 2 | 3 | 4 | 5 |

3. Your doctor knows what he or she is doing.

| 1 | 2 | 3 | 4 | 5 |

4. Your doctor is dedicated to his or her work.

| 1 | 2 | 3 | 4 | 5 |

5. Your doctor is compassionate.

| 1 | 2 | 3 | 4 | 5 |

6. Your doctor is consistent in his or her diagnosis and treatment of your illness.

| 1 | 2 | 3 | 4 | 5 |

7. Your doctor is religious.

| 1 | 2 | 3 | 4 | 5 |

8. Your doctor responds to your requests.

| 1 | 2 | 3 | 4 | 5 |

9. Your doctor appears to be concerned about your well-being.

| 1 | 2 | 3 | 4 | 5 |

10. Your doctor treats all of his or her patients equally.

| 1 | 2 | 3 | 4 | 5 |

11. Your doctor makes helpful and reasonable recommendations.

| 1 | 2 | 3 | 4 | 5 |

12. Your doctor explains things so that you understand them.

| 1 | 2 | 3 | 4 | 5 |

| | | Not Sure/ | | Strongly |
Strongly Agree	Agree	Neutral	Disagree	Disagree
1	2	3	4	5

13. Your doctor looks as though he or she is trying to help you out.
       1   2   3   4   5

14. Your doctor shows that he or she is familiar with your health.
       1   2   3   4   5

15. Your doctor treats you like a person, not just a number.
       1   2   3   4   5

16. Your doctor treats you like a personal friend.
       1   2   3   4   5

17. Your doctor acts like he or she is interested in more than just making money.
       1   2   3   4   5

18. Your doctor follows a common procedure for treating all of his or her patients.
       1   2   3   4   5

19. Your doctor shows that he or she remembers you.
       1   2   3   4   5

20. Your doctor consults with others to help you.
       1   2   3   4   5

21. Your doctor correctly diagnoses and treats your illness.
       1   2   3   4   5

22. Your doctor is NOT scared to touch you.
       1   2   3   4   5

23. You doctor calls to check up on how you are feeling.
       1   2   3   4   5

24. Your doctor takes your concerns seriously.
       1   2   3   4   5

25. Your doctor tries to communicate with you.
       1   2   3   4   5

26. Your doctor talks to you during your visit.
       1   2   3   4   5

27. Your doctor does NOT look down on you.
       1   2   3   4   5

28. Your doctor prescribes medicine only when he or she is sure of your illness.
       1   2   3   4   5

29. Your doctor is available for you.
       1   2   3   4   5

30. Your doctor listens to you.
       1   2   3   4   5

31. Your doctor takes his or her time with you during your visit.
       1   2   3   4   5

32. Your doctor lets you explain your symptoms before examining you.
       1   2   3   4   5

	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
	1	2	3	4	5

33. Your doctor examines you carefully before making any decisions.
   1   2   3   4   5
34. Your doctor refers you to a specialist when he or she cannot help you.
   1   2   3   4   5
35. Your doctor explains everything he or she does to you.
   1   2   3   4   5
36. Your doctor prescribes medicine only when he or she is sure of your illness.
   1   2   3   4   5
37. Your doctor does not make you wait long.
   1   2   3   4   5
38. Your doctor puts on a fresh pair of rubber gloves while you are in the examining room.
   1   2   3   4   5
39. Your doctor looks professional.
   1   2   3   4   5
40. Your doctor follows up on your visits.
   1   2   3   4   5
41. Your doctor understands your financial situation.
   1   2   3   4   5
42. Your doctor knows how to make you feel comfortable.
   1   2   3   4   5
43. Your doctor talks to you before making decisions about prescriptions and treatment.
   1   2   3   4   5
44. Your doctor comforts you.
   1   2   3   4   5
45. Your doctor has a positive attitude.
   1   2   3   4   5
46. Your doctor makes you feel appreciated.
   1   2   3   4   5
47. Your doctor keeps up with new research and treatment.
   1   2   3   4   5
48. Your doctor treats you with respect.
   1   2   3   4   5
49. Your doctor shows care and concern for your child.
   1   2   3   4   5
50. Your doctor makes you feel special.
   1   2   3   4   5
51. Your doctor tries to help you out.
   1   2   3   4   5
52. Your doctor creates positive feelings during your visit.
   ·1   2   3   4   5

	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
	1	2	3	4	5

53. Your doctor is nice.

    1   2   3   4   5

54. Your doctor is informative to you.

    1   2   3   4   5

55. Your doctor is sensitive to your needs.

    1   2   3   4   5

56. Your doctor speaks English well enough for you to understand what he or she is saying.

    1   2   3   4   5

57. Your doctor understands the African American culture.

    1   2   3   4   5

58. Your doctor mingles with the African American community outside of the clinic.

    1   2   3   4   5

59. Your doctor lets you know about illnesses and diseases common among African Americans.

    1   2   3   4   5

60. Your doctor has training in working with African American patients.

    1   2   3   4   5

61. Your doctor prepares you for the next steps in treating your illness.

    1   2   3   4   5

62. Your doctor puts your mind at ease.

    1   2   3   4   5

63. Your doctor is polite.

    1   2   3   4   5

64. Your doctor is respectful of your religious beliefs.

    1   2   3   4   5

65. The clinic is clean.

    1   2   3   4   5

66. The clinic is comfortable.

    1   2   3   4   5

67. The clinic is calm.

    1   2   3   4   5

68. The clinic has procedures to ensure that you are seen by the doctor at the time of your appointment.

    1   2   3   4   5

69. The clinic has a social worker on the premises available to help you with insurance and disability problems.

    1   2   3   4   5

70. The clinic is professional looking like a clinic should be.

    1   2   3   4   5

	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
	1	2	3	4	5

71. The clinic has doctors and nurses moving visibly about treating patients.
       1   2   3   4   5
72. The clinic has a playpen for children.
       1   2   3   4   5
73. The clinic staff allows you to discipline your children while you are inside the clinic.
       1   2   3   4   5
74. The clinic has large, spacious waiting rooms.
       1   2   3   4   5
75. The clinic has procedures to ensure that neither patients nor staff are allowed to gossip.
       1   2   3   4   5
76. The clinic has warm examining rooms.
       1   2   3   4   5
77. The clinic has affordable services.
       1   2   3   4   5
78. The clinic is open late to accommodate people who work.
       1   2   3   4   5
79. The clinic has magazines geared toward African Americans like Ebony, Essence, and Jet.
       1   2   3   4   5
80. The clinic has a TV turned on.
       1   2   3   4   5
81. The clinic has entertainment for children.
       1   2   3   4   5
82. The clinic has pictures on the wall.
       1   2   3   4   5
83. The clinic has the same doctors all of the time.
       1   2   3   4   5
84. The clinic has African American doctors working at the clinic.
       1   2   3   4   5
85. The clinic has brochures available about illnesses or diseases common to African Americans.
       1   2   3   4   5
86. The clinic has many convenient places to park.
       1   2   3   4   5
87. The clinic has short waiting times to see the doctors.
       1   2   3   4   5
88. The clinic has music playing in the examining rooms.
       1   2   3   4   5
89. The clinic has volunteer doctors to reduce waiting time.
       1   2   3   4   5

Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
1	2	3	4	5

90. The clinic has reading material you can use to diagnose yourself..

    1   2   3   4   5

91. The clinic has large examining rooms.

    1   2   3   4   5

92. The clinic has waiting room chairs arranged so that you do not touch other patients when you sit.

    1   2   3   4   5

93. The clinic has procedures to ensure that you are treated within 15 minutes of your appointment.

    1   2   3   4   5

94. The clinic has separate rooms for children and adults.

    1   2   3   4   5

95. The clinic has waiting rooms that make it easy for patients to talk to each other.

    1   2   3   4   5

96. The clinic has examining rooms with distractions for patients.

    1   2   3   4   5

97. The clinic has waiting rooms that are NOT crowded.

    1   2   3   4   5

98. The clinic has procedures to ensure convenient scheduling of patients.

    1   2   3   4   5

99. The clinic has music playing in the waiting room.

    1   2   3   4   5

100. The clinic has flowers or plants.

    1   2   3   4   5

101. The clinic has fresh air.

    1   2   3   4   5

102. The clinic is odorless.

    1   2   3   4   5

103. The clinic has comfortable chairs in the waiting room.

    1   2   3   4   5

104. The clinic has many chairs in the waiting room.

    1   2   3   4   5

105. The clinic has African American staff working at the clinic.

    1   2   3   4   5

106. The clinic has warm waiting rooms.

    1   2   3   4   5

107. The clinic has a hotline you can call for illness information.

    1   2   3   4   5

108. The clinic has signs and posters about illnesses and procedures on the walls.

    1   2   3   4   5

	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
	1	2	3	4	5

109. The clinic has a sign-in sheet.

    1   2   3   4   5

110. The clinic has many receptionists and staff members working.

    1   2   3   4   5

111. The clinic has pictures of well-known African American doctors in the history of medicine.

    1   2   3   4   5

112. The clinic has African American art.

    1   2   3   4   5

113. The clinic has an entrance that allows patients to walk in without being noticed by everyone in the waiting room.

    1   2   3   4   5

114. Your doctor chats with you during your visit.

    1   2   3   4   5

115. The clinic is freshly painted.

    1   2   3   4   5

116. The clinic has procedures to help you financially with traveling to and from the clinic.

    1   2   3   4   5

117. The clinic staff calls you the day before your appointment to confirm it.

    1   2   3   4   5

118. The clinic staff is willing to "pull some strings" to try to help you.

    1   2   3   4   5

119. The clinic staff admits you quickly after your initial registration as a patient.

    1   2   3   4   5

120. The clinic staff is friendly.

    1   2   3   4   5

121. The clinic staff appears concerned about your well-being.

    1   2   3   4   5

122. The clinic staff gets back with you as promised.

    1   2   3   4   5

123. The clinic staff is welcoming.

    1   2   3   4   5

124. The clinic staff offers to give you money for haircuts and to wash your clothes if you cannot afford these things.

    1   2   3   4   5

125. The clinic staff works with your case even if you cannot pay the doctor's bills.

    1   2   3   4   5

126. The clinic staff is helpful.

    1   2   3   4   5

	Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
	1	2	3	4	5

127. The clinic staff is professional.

        1   2   3   4   5

128. The clinic staff treats you with respect.

        1   2   3   4   5

129. The clinic staff does not discriminate against you because of your race.

        1   2   3   4   5

130. The clinic staff knows your name.

        1   2   3   4   5

131. The clinic staff gets the doctor to see you at the time of your appointment.

        1   2   3   4   5

132. The clinic staff pays attention to you.

        1   2   3   4   5

133. The clinic staff listens to your complaints.

        1   2   3   4   5

134. The clinic staff is pleasant.

        1   2   3   4   5

135. The clinic staff is polite.

        1   2   3   4   5

136. The clinic staff knows your children's names.

        1   2   3   4   5

137. The clinic staff does not grab your children from you.

        1   2   3   4   5

138. The clinic staff lets you know if there are any changes to your record.

        1   2   3   4   5

139. The clinic staff treats you like a person, not like a number.

        1   2   3   4   5

140. The clinic staff does not look down on you.

        1   2   3   4   5

141. The clinic staff keeps your business confidential.

        1   2   3   4   5

142. The clinic staff lets you call them by their first name.

        1   2   3   4   5

143. The clinic has the same staff all of the time.

        1   2   3   4   5

144. The clinic staff takes care of you as soon as you walk in.

        1   2   3   4   5

145. The clinic staff gives you a card to remind you of your next appointment.

        1   2   3   4   5

146. The clinic staff does not gossip about patients.

        1   2   3   4   5

Strongly Agree	Agree	Not Sure/ Neutral	Disagree	Strongly Disagree
1	2	3	4	5

147. The clinic staff does what the doctor told them to do for you.

    1   2   3   4   5

148. The clinic staff works quickly to process your paperwork before and after you see the doctor.

    1   2   3   4   5

149. The clinic staff does not make unprofessional comments.

    1   2   3   4   5

150. The clinic staff allows you to reschedule a missed appointment within a reasonable time.

    1   2   3   4   5

151. The clinic staff makes fair decisions about who the doctor is going to see next.

    1   2   3   4   5

152. The clinic staff is skilled at working with people.

    1   2   3   4   5

153. The clinic focuses more effort on attending to patients in the clinic than on answering phone calls.

    1   2   3   4   5

154. The clinic staff does not stereotype African American patients as illiterate and uneducated.

    1   2   3   4   5

Dear Veteran:

I am taking this opportunity to inform you about the important study enclosed in this packet and being conducted by our staff at the Syracuse VA Medical Center. This research project will be exploring ways of learning more about and improving the health care experiences of African American Veterans such as yourself. This research could provide our staff with valuable information about how to improve the health of our African American patients.

As the Coordinator of Minority Veterans at the Syracuse VA Medical Center, I strongly endorse this research project and strongly encourage your participation.

Sincerely,

Odie Freeman, MSW, CSW, ACSW
Minority Veterans Coordinator

PATIENT INVITATION COVER LETTER

Dear Veteran: Date: _____

Thank you for your interest in a research project that we are conducting. As you may recall, during a recent phone call we invited you to participate in a study that we are conducting regarding the health care experiences of African American patients who have received outpatient primary care services at the Syracuse VA Medical Center within the last 24 months. This research is being conducted by myself, Dr. Robert Sprafkin, Senior Psychologist at the Syracuse VA Medical Center, and Todd Walter, Psychology Extern at the Syracuse VA Medical Center and Doctoral Candidate in Counseling Psychology at the University of Florida.

The focus of our research project is to examine what physician (health care provider) behaviors and health care setting factors that patients regard as culturally sensitive, as well as how satisfied they are with the health care that they receive. This information is very important because it will help us to better understand how we can improve the medical care services that we provide to you and other African American Veterans. Our hope is that this information will help us not only improve the quality of care and quality of life that patients such as yourself experience, but will help us to improve the health status and outcomes of our African American Veteran patients.

Your participation in this research is voluntary. If you agree to participate in this project, you will be paid $15 for your participation. In order to participate, please read and sign both of the informed consent forms included in this packet, and complete the questionnaires that are enclosed. These questionnaires should only take about 30 minutes to complete. If you need help completing these questionnaires, you may get assistance from a family member or friend to help you (although we only want your opinions to the questions). If you do need assistance completing the enclosed questionnaires but do not have a family member or friend who can assist you, you may call Dr. Sprafkin or Mr. Walter at (315) 476-7461, ext. 3227, to set up an appointment to have the questionnaires read to you by one of us at the Syracuse VA Medical Center.

If you agree to participate in this research project, the information that you provide will not be shared with your doctor or other members of the health care staff. Your name will not be placed on the information. The information will be assigned an identity code. The names, which identify the codes on the information, will be kept separate from the information that you provide us and will be destroyed as soon as all information from research participants has been obtained. The information will be kept in a locked file in

Dr. Sprafkin's office at the Syracuse VA Medical Center. Your information will be summarized as group data and your individual responses will not be shared.

Please read the enclosed informed consent forms and sign your name in the space indicated on the forms if you agree to participate. Please return <u>one signed</u> copy of the informed consent (keep the other copy for your records) <u>and all of the completed questionnaires</u> in the enclosed self-stamped envelope no later than three (3) weeks from the date on this letter. You will receive payment of $15 within three (3) weeks of when we receive your returned information. If you have any questions regarding the research project, please call Mr. Todd Walter or Dr. Robert Sprafkin at (315) 476-7461, ext. 3227.

Thank you for taking the time to read this letter. We are looking forward to hearing from you and hope that you will agree to participate.

Sincerely,

Dr. Robert Sprafkin
Senior Psychologist
Department of Veteran Affairs Medical Center, Syracuse, New York

Todd J. Walter
Psychology Extern, Department of Veteran Affairs Medical Center, Syracuse, New York
Doctoral Candidate in Counseling Psychology, University of Florida

Enclosures

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BIOGRAPHICAL SKETCH

Todd Joseph Walter is the son of Wayne and Barbara Walter. He is the youngest of three children and was born and raised in Western New York state. He completed his undergraduate degree in psychology at Niagara University in 1992, graduating magna cum laude. He thereupon entered the State University of New York (SUNY) at Buffalo, eventually earning his Master's degree in psychology in 1995.

Todd entered the doctoral program in counseling psychology at the University of Florida in the fall of 1994. He married his wife, Lora, in the winter of 1994. He completed his pre-doctoral internship at the VA Medical Center in Syracuse, New York, in August 1999. Todd is employed as an adjunct faculty member at Niagara University, SUNY at Buffalo, and Jamestown Community College. He plans to graduate in August 2001 with a Ph.D. in counseling psychology. Todd has accepted an appointment as an Assistant Professor of Psychology at D'Youville College in Buffalo, NY, beginning in the fall 2001.

In his spare time, Todd enjoys relaxing and spending time with his family and friends. He enjoys traveling, reading, the theater, watching movies, and participating in and watching various sports. Todd became an avid Florida Gators fan while at the University of Florida and attended many sports and social activities. These activities in conjunction with his academic pursuits offered him the opportunity to meet and make many friends who have greatly enriched his personal and professional development.

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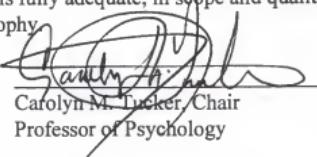
Carolyn M. Tucker, Chair
Professor of Psychology

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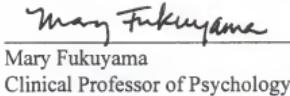
Mary Fukuyama
Clinical Professor of Psychology

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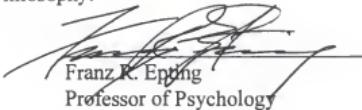
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Professor of Psychology

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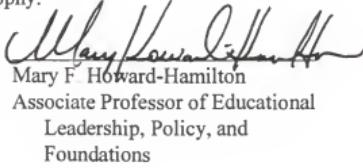
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Associate Professor of Educational
   Leadership, Policy, and
   Foundations

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Science and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree Doctor of Philosophy.

August 2001

Winfred M. Phillips
Dean, Graduate School